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AN INTIMATE ACCOUNT OF THE ORIGIN AND GROWTH OF THE MENTAL-HYGIENE MOVEMENT *

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TO have such a distinguished audience as this pay me the high compliment of standing up when I was introduced should, I suppose, embarrass me. But, frankly, it does not. I can accept your tribute with equanimity because I appreciate that it belongs to the cause. I shall simply act as custodian of it, reserving the right to dip into the memory of it, as one would into surplus savings, when difficult situations in the development of the work arise—as they inevitably will on occasion in the future. To-night I need no praise. The success of this Congress is reward enough.

I am glad that the previous speaker, Canon Stokes, quoted the remark made by Dr. Diefendorf at the founding meeting of the pioneer Connecticut Society for Mental Hygiene, twenty-two years ago to-day. The fact that he, a psychiatrist, thought it necessary to assure those who appointed me secretary of that society that "Mr. Beers is now sane" reflects as no other statement could have done the atmosphere of suspicion in which I began my work. In those days, a generation ago, almost every one believed that to be once insane was to be always insane. Now, thanks to the campaign of education that has been carried on by mental-hygiene societies,

* Address delivered at the opening evening session of the First International Congress on Mental Hygiene, Washington, D. C., May 6, 1930.

the public is beginning to have a rational attitude toward "insanity" and realizes that a fair proportion of those who suffer mental breakdowns recover and remain well, and that thousands of others recover sufficiently to merit discharge from the hospitals or, as I frequently remark, are restored to a state of mental health as good, at least, as that enjoyed by many who never suffer commitment to an institution.

Canon Stokes, who told me in advance of his intention to quote Dr. Diefendorf's remark, said that I might tell this audience that I was the only one present at that first mental-hygiene meeting whose mental health was vouched for by a psychiatrist! May I here and now pay a tribute to the psychiatrist, Dr. Diefendorf, who had the temerity publicly to proclaim my sanity at a time when many residents of my native city, New Haven, thought my plans grandiose and felt, as I learned later, that I was in need of a further course of treatment.

By the way, I do not make addresses. I simply get up and talk, hoping that some of the things I say may be of interest to the audience. In not writing out speeches in advance, I conserve energy. Dr. Welch tells me he has followed this plan for years, and he, as you know, has just celebrated his eightieth birthday. Both of us agree that if any suffering is to be endured, the audience, not the speaker, should be the victim. From the speaker's standpoint this is good mental hygiene.

I might to-night trace the growth of the work in terms of institutions and clinics and other centers of help that have been established, and I might trace the growth by describing various phases of mental-hygiene work. Instead, however, I have decided to outline the progress made in terms of a few of the men and women who have helped me toward my goal.

In my autobiography I paid a tribute to my parents. To-night I wish to be a little more specific. Without an impulse to reform conditions among the insane, I should never have written *A Mind That Found Itself* or embarked upon my career. That impulse to "reform" was a trait inherited, I believe, from my mother. Her sympathies were easily aroused by accounts of injustice and hardship among the

less fortunate. Had she been born a generation or two later than she was, she would no doubt have been active in one or more of the organizations through which women to-day express their desire to improve conditions. From my mother I inherited also at least some gift for literary expression. She had a command of language and, as in my own case, few inhibitions in regard to expressing her opinions—a valuable trait, you will, I am sure, admit in one who embarks upon such a career as mine. From my father, I inherited traits that enabled me to put to good use the traits inherited from my mother. He was ever and always hopeful and persistent, unusually so.

My part, therefore, in the mental-hygiene movement is the product of heredity and of certain traits and impulses—to "reform", to talk and write in the interests of betterment of conditions; to be so hopeful of results as to be confident of producing them; and to strive for my goal persistently, once my mind is made up.

That I should aspire to write a book and start this movement was, as I have intimated, looked at askance by almost every one in the beginning. They seemed to think it was harmful for me to dwell upon my past experiences, whereas it proved to be, for me at least, beneficial. But there were two friends of my youth who did believe in me and who encouraged me in my ambitions.

One was my boyhood friend, Victor Morris Tyler, who supported his opinion by timely loans finally paid back out of the gift made me by Mr. Henry Phipps which is described in my book. The other was she who later became my wife. Those who have read my book are deeply indebted to her. It is not always what is in a book that makes it readable, but what is left out. Lincoln is called the Great Emancipator. It was my wife who proved to be the Great Eliminator—of passages which I, because of my enthusiasm and lack of objectivity at the moment, cherished at the time of writing and would have published except for her timely criticism.

You, to-night, are hearing of plans that have been worked out. She who became my wife four years after my book was published in 1908, and became, as I like to say, the real royalty on it, has performed a burdensome duty in listening to all of

my plans, including those that were discarded for one reason or another. Great credit for such success as I have achieved is due her.

Part of the success attained by me in my work can be traced to my willingness to do things that almost all who have been patients in a mental hospital are loath to do. For instance, instead of keeping away from psychiatrists, as ex-patients usually prefer to do, I organized a National Committee, the nature of whose work made it necessary for me to surround myself with a large group of psychiatrists, and most of the work I have done during the past twenty years has been done with one or another psychiatrist within sight, if not at my side. You may think this is a brave thing to have done. Not at all. Though working exclusively with one psychiatrist might be dangerous—unless he were possessed of the rare insight shown by Dr. Diefendorf—working with a group of them is the safest thing in the world. A group of psychiatrists, as records of "expert" testimony show, could never agree, and a former patient would always find several in the group who would certify to his sanity, if the question were raised. In this connection it seems not amiss to say that probably I know more about the mental rating of the psychiatrists of America than any other layman! Perhaps I'll publish a book some day of thumb-nail sketches of them. At any rate, it would be but poetic justice for some ex-patient to do this, under the title, perhaps, of *The Examiners Examined.*

The third person who played a determining part in my work was William James, who became a most loyal friend and supporter. I went to see him at his home in Cambridge, Massachusetts, in June 1906, using an early draft of my manuscript as a letter of introduction. He received me cordially, but, pointing to a pile of unread manuscripts on his desk, said it might be months before he could find time to read mine. Nevertheless, he read it promptly, perhaps because of a long-standing interest in the care of the insane, and sent me the approving letter that served later as part of the introduction to the first edition of my book. Though Professor James's approval was not that of a psychiatrist, it marked the turning point in my struggle for support. With

him on record in regard to the psychological and literary value of my story, the psychiatrists soon gave their approval.

I have always believed in enlisting the interest of those at the top, if possible, knowing that if one gains the support of leaders, every one else will eventually follow. Having gained the approval of America's greatest psychologist, I set out to secure the support of the leading psychiatrist, Dr. Adolf Meyer. What I was trying to accomplish proved to be in line with some of his hopes and plans in regard to better care and treatment for the mentally ill and for work in prevention. In consequence, he came to my support and gave me a letter which also appears in my book. He also edited my story, then in page-proof form, and kept me from making errors in statement which I, a layman, would inevitably otherwise have done. But Dr. Meyer did not ask me to change my narrative. That, he said, was my own story, and just such a story was needed to improve conditions in the institutions. As a matter of record, I wish to remind you that it was Dr. Meyer who suggested "mental hygiene" as the words to use in naming the National Committee—and the movement. To William James and to Dr. Adolf Meyer I owe an unrepayable debt—and so does our cause.

Then came the task of finding a publisher and borrowing the money needed for publishing my book—I having resolved to own the copyright in the interests of the movement. The first publisher to whom the manuscript was submitted accepted it. Then I searched for some one who would lend me the money needed for printing the first edition of 3,000 copies. Times were hard in the winter of 1907, when there was what was called a "rich man's panic", and it finally became necessary for my eldest brother to come to the rescue. Fortunately, however, the first edition sold rapidly, because of the nation-wide publicity given my story, owing to its having what is called "news value", and I was able within the year to repay my brother what he had so courageously advanced. But, I may say, I did not feel there was any risk in the transaction, since I was confident, even while writing my story, that it would enjoy a good sale, much larger in fact than it really has. If it has never been ranked as a best seller, the book has, nevertheless, been printed seventeen

times during the past twenty years, and is still selling, and better now than ever before. Publishers tell me that few books have so many printings over so long a period. That mine has had is due to the growing interest in the movement it helped to start.[1]

The group that sponsored the pioneer National Committee for Mental Hygiene, sponsored, through me, the founding of the pioneer state society for mental hygiene, that of Connecticut, founded on May 6, 1908, just twenty-two years ago to-day. The National Committee was formally founded a few months later, on February 19, 1909.

It was not from choice that I first launched a state society. I wanted to start the movement on a nation-wide scale. But funds were lacking. So I continued to go into debt to further my project, confident in the belief that some person of wealth would eventually see the opportunity as I saw it.

At this point in the development of the movement, two leading Americans played vital rôles: Dr. William H. Welch, the honored chairman of this meeting, who has been a high officer of our National Committee since the beginning, and Mr. Henry Phipps, one of the most far-seeing of our philanthropists. Mr. Phipps, who had by that time read my book, one day told Dr. Welch that he was ready to give $50,000 "to ameliorate conditions among the insane", and left it to Dr. Welch to suggest how best to do it. Imagine the thrill I got about four years after my project had been launched—by which time I was ten thousand dollars in debt on account of it—when I received a letter from Dr. Welch saying he knew where he could get $50,000 for our National Committee—if we could submit a satisfactory plan for using the money. The plan was promptly submitted and the money was soon in the treasury of our National Committee. A little later Mr. Phipps sent for me and presented me with a gift of $5,000 for my own use, in recognition of my services. This I used at once in canceling half of the debts incurred in starting the movement. Such miraculous happenings as these have,

[1] The copyright of *A Mind That Found Itself* was purchased from the author in January, 1931, by The American Foundation for Mental Hygiene, Inc., and all future royalties, and profits on its sale, will go to the Foundation. Under this arrangement the book can, with propriety, be sold in an organized way in the interests of the mental-hygiene movement.

at intervals, marked the progress of events in my work and have served to compensate for hardships endured earlier. Furthermore, knowing and winning the support of a number of outstanding leaders, at home and abroad, as my work has progressed is also a compensating privilege which Fate grants to comparatively few. Is it surprising that I feel that my mental breakdown of thirty years ago was distinctly worth while?

Two more personalities stand out in the history of the work: Dr. Thomas W. Salmon, who became the medical director of our National Committee in March, 1912, and served for ten years, when he resigned to become professor of psychiatry at Columbia University; and Dr. William L. Russell, one of our leading psychiatrists, who has aided our National Committee and me continuously for over twenty years. It was Dr. Russell who, as it were, discovered Dr. Salmon, at least in relation to our work, and it was Dr. Salmon who placed the active work of our National Committee and, indeed, of the whole movement, on a sound and scientific basis when few even glimpsed its possibilities for growth and usefulness. His place in the history of the movement is a lasting one. For that reason, and because he would now be taking a prominent part in this Congress if he were alive, I shall incorporate at the end of this address, in the Proceedings of this Congress, a deserved and beautifully worded tribute to his memory, written by Dr. Haven Emerson, so that a more adequate record of Dr. Salmon's contribution to our movement may be preserved and read by people in all countries.

It is possible, with the limited time at my disposal, to mention only a few of all who have played a distinctive part in the progress of our work, such as Professor Russell H. Chittenden and the Reverend Anson Phelps Stokes, D.D., who were most active in the beginning and have followed the work through all these years; Dr. Bernard Sachs, Dr. William A. White, and Dr. Arthur H. Ruggles of our Executive Committee; and the late Dr. August Hoch, Dr. Walter E. Fernald, Dr. Walter B. James, Dr. Charles W. Eliot, and Mr. Otto T. Bannard, through whose deaths our work and the nation suffered great loss. But I do wish in this record of the progress of the movement to give specific credit to my friend and asso-

ciate, Dr. Frankwood E. Williams, who succeeded Dr. Salmon as medical director of our National Committee and has served so efficiently in that position for the last eight years, for the remarkable progress made during those years. Though Dr. Williams' contributions have been many—witness the quality and success of the program of this Congress, which he formulated—his most distinctive contribution has probably been the work done as editor of MENTAL HYGIENE ever since it first appeared in 1917, when he joined the staff of our National Committee. This magazine which, in a sense, has been the official quarterly of the whole mental-hygiene movement, has had a profound effect in all countries and has greatly furthered the progress of the movement. Dr. Williams, of his own choice, will soon resign as medical director of our National Committee, to engage in private practice and in studies and researches in which he is especially interested. He has earned relief from the exacting duties that go with the position of medical director of our National Committee, and he will take with him into his new field of activities the good wishes of us all.

The record of those who have played distinctive parts in the progress of the work, at least in this country, would not be complete without mention of the late Mrs. Elizabeth Milbank Anderson and Mrs. William K. Vanderbilt, Sr., who contributed liberally in a crisis in 1914 that threatened the continued existence of our National Committee. Their gifts carried the work along until we were able to secure support from the Rockefeller Foundation, the Commonwealth Fund, the Milbank Memorial Fund, and the Altman Foundation, the first two organizations named having given several hundred thousands each, largely for surveys, special studies, and demonstrations. And four years ago, a generous donor, whose name I forbear to publish, lest she be overwhelmed with appeals, had the vision to peer behind the scenes, as it were, and lift me off the pay roll of our National Committee by guaranteeing my salary for ten years and paying it to me directly. The advantages to me and to the work of such an ideal arrangement are self-evident.

I have sketched the growth of the movement in this country in terms of a few of those who were most active in its de-

velopment during the most difficult years. Now let me outline the growth of it internationally.

In the year 1917, Dr. C. M. Hincks, of Toronto, visited our office in New York, talked with me, and after learning about our work, returned home and organized The Canadian National Committee for Mental Hygiene. This was an event I had been waiting for, because, with a second national committee in existence in another country, the movement became international. About a year later, on February 4, 1919, I brought a group together in New York City and formally launched the international movement through the appointment of an organizing committee, which, as many of you know, sponsored the International Committee, founded to-day, and also crystallized interest in the holding of this First International Congress on Mental Hygiene—two projects financed in their earliest stages by Mrs. Elizabeth Milbank Anderson, of New York; Mrs. David A. Dunlap, of Toronto, Canada; and Mrs. John Wood Blodgett, of Grand Rapids, Michigan.

Though the plans for holding this Congress and founding the International Committee were not put into effect as soon as I had anticipated, it having taken eleven years to bring them to realization, progress was made during that period in spreading the movement, as evidenced by the organizing of national organizations for mental hygiene in a number of countries, representing all of the continents. Indeed, it should not be long now before all countries and all of the states in this country will have societies for mental hygiene through which interest in our movement can be expressed in an effective way.

In closing I wish to say something about the financing of mental-hygiene organizations. To-night, in the presence of this great audience, I feel like a million dollars, and the work of our National Committee, which I have said so much about because I know more about it than about any other organization, must look to you like many millions of dollars. The fact is, however, that keeping our work financed has, at times, been a heart-breaking struggle, the burden of which has fallen largely on me, perhaps because I started it and because I have learned how to ask for support. Part of the difficulty has been that the need for our work has grown far more

rapidly than the public's understanding of it. As a result, we have usually been faced with discouraging deficits, which could be covered only through securing large gifts from a few people of wealth, it having been impossible, thus far, to secure substantial support from the general public in the form of a large number of nominal annual contributions, because mental hygiene, as a subject, is not easily understood and is difficult to explain in brief letters of appeal and printed folders. In consequence, it will be years before adequate support can be secured from the public in this way.

But I venture to predict that the day will come when mental-hygiene work will be liberally financed. I base this prediction upon a number of observations—namely, the permanently interesting character of the varied and many topics dealt with under the general heading of "mental hygiene"; the many and numerically great groups of the population, totaling millions, that can be benefited, directly or indirectly, by mental-hygiene work, including normal individuals who will never break down nervously or mentally; and the rapidly growing realization that many of the most difficult social problems of the day can never be solved until the mental factors involved in them are given due recognition.

Another reason for believing in the future financial stability of the movement is that mental-hygiene ideas and appeals have within the past year received significant recognition in direct competition with practically all other forms of social and philanthropic work. Witness the decision of the judges in a contest conducted by a New York newspaper, which asked for ideas as how best to give away several millions of dollars "for the benefit of humanity". The winning plan, out of one hundred thousand submitted, was one relating to a mental-hygiene project. Witness also the decision of the Committee on Distribution of the Conrad Hubert Estate, of which President Coolidge, Governor Alfred E. Smith, and Mr. Julius Rosenwald were the members. Of the thirty organizations that received gifts, out of the six or eight hundred that submitted appeals, our National Committee was one of the fortunate few, it being given an award of $250,000. Such things as this could not happen in direct competition with practically all other forms of health, welfare,

and educational work, if our work were not on the way to its destined place in the sun of public approval and support.

The success, too, attained during the past two years by The American Foundation for Mental Hygiene is not without significance. This organization, which is closely affiliated with our National Committee, was established in 1928 for the purpose of serving as custodian and dispenser of funds for any sort of mental-hygiene work, anywhere. Within the past two years it has received several large gifts, one of $20,000, one of $50,000 (which was used to finance the basic expenses of this International Congress), and one of $100,000. In addition, bequests to it to the amount of about $700,000 have been incorporated in wills definitely known about. It is my belief that this Foundation will *eventually* have many millions of dollars at its disposal for use in developing one phase or another of mental-hygiene work, and, in crises, coming to the rescue of various organizations in our field, thus protecting the movement until the general public is educated into supporting such work as ours as liberally as it already supports such work, for instance, as is being done in the more easily understood field of tuberculosis. But please do not get the impression that these high hopes for the future financial stability of our work mean that we do not need contributions and gifts for the work immediately ahead. We need help urgently and I hope that some of those present will aid us in getting it. Furthermore, provision for the future work might well be made through bequests to our National Committee or to The American Foundation for Mental Hygiene, for the benefit of the National Committee or the movement in general. It seems not amiss for me to suggest that those engaged in work in our field and those, especially, whose families have suffered a mental affliction, should consider providing in their wills for bequests, large or *small*, to this Foundation, so that there may be a pooling and increase of resources for use in developing mental-hygiene work everywhere.[1]

I have said little about the causes of mental breakdowns.

[1] Upon request, copies may be had of a publication issued by The American Foundation for Mental Hygiene, Inc. (450 Seventh Avenue, New York City), which describes its purposes, plans, and personnel and includes suggested legal forms for use in making bequests.

That is a subject about which you will hear much from the psychiatrists at this Congress. But there is one form of mental strain that I do feel able to discuss—the strain caused by deficits, which in the progress of our National Committee's work have recurred with painful frequency. Deficit is a word that strikes terror to persons engaged in social work, quite as much as to those engaged in business and governmental affairs. If I had my way, the word would be eliminated from all dictionaries. But before it is buried in oblivion, let me embalm it by quoting a joke I heard while in my 'teens, long before the word had any unpleasant connotation in my mind, a joke I have never seen in print or heard quoted by any one else. Lew Fields, a comedian, well known in this country, used the word "deficit" in a verbal encounter with his team-mate, Joe Weber. "What is a deficit?" Weber asked. "You don't know what is a deficit?" Fields said. "A deficit is just like money, only there's more of it!" As to deficits, there are always more of them than of money in such work as ours. But the reverse will be true, in our field at least, when the mental-hygiene movement comes into its own.

I do not wish to leave you with the impression that our National Committee and I have accomplished all that has been done in furthering the mental-hygiene movement. Its success is the result of the efforts of many men and women in many countries. The attendance at this Congress proves that. To me, of course, this event and this celebration of the founding of the movement twenty-two years ago is thrilling. May I again thank all of you for coming and express the hope that we may all meet again at the Second International Congress, to be held in Paris, the city in which Pinel, during the French Revolution, when mass madness was so evident, demonstrated at that historic hospital, the Bicêtre, that the so-called insane were not possessed of demons, but were, in fact, sick people deserving of humane care and the best of treatment.

THE PSYCHOSEXUAL DEVELOPMENT OF THE CHILD

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PROBLEM behavior as seen in the clientele of a child-guidance clinic is the visible evidence of a conflict. In a certain number of instances, this conflict is the result of an environment that is making excessive demands on the child, or of an environment that is not too demanding for the average child, but is for the child who is not average physically or intellectually. In other instances, a child who is average intellectually and physically is showing problem behavior in an average environment. In such a child, though the results of the conflict are seen in his behavior—in his relation to the environment—the conflict itself lies within the child, between the components of his personality. To the average clinic worker such cases are puzzling. The following résumé of the manner of development and function of the components of the personality and their rôle in the history of the child's development are presented to aid the worker to a better understanding of such cases.

The personality of any individual consists of three parts:

1. The id—the reservoir of the fundamental instinctual desires. As the biological aim of life is the reproduction of the species, such desires are mainly sexual. The physical organism produces energy for the use of this instinct, and this instinct energy (libido), which is present in every human being, demands outlet. If no outlet is found, tension and consequent discomfort arise, of which the individual must rid himself, for every living organism tries to relieve discomfort—*i.e.*, seeks the pleasure of relief from tension. The direct outlets for this instinct energy are unmoral and unsocial, showing themselves under the guise of sexual love, self-love, hate, cruelty, exhibitionism, curiosity, and so forth. Such direct and immediate expression is possible physiologically and socially only very early in life. The

development of the child's personality—his psychosexual development [1]—consists in his learning to control the mode of their expression—for expressed they must be. That is, he has to learn to relinquish direct expression and the infantile behavior whereby it takes place and to control himself in accordance with the dictates of the social organization. He does this by developing two other parts of his personality.

2. His ego or critical perceptive faculty. This is his awareness of himself as an individual and of the world in which he lives. Through this faculty he tries to relieve his id tensions by allowing the instinct energy outlets that accord with the dictates of reality—*i.e.*, of the physical and social world.

3. The super-ego or internal conscience. The ego is in direct contact with the real outside world through the central nervous system, but being conscious, is largely unaware of the nature and direction of the instinctual impulses to be controlled. Also, during the formative period, it is too weak to cope with the problem of adjusting the expression of id desires to the demands of reality, so that the child depends on help from his parents. This parental training he later incorporates into his unconscious personality as his super-ego or internal conscience, whose function is to warn the ego of the tension due to id impulses and to help him control their expression.

The id is inborn, inherent, and remains unaltered from birth to death. The problem confronting every human being is the development of control over his impulses. In order to understand how the powers of control develop, it is necessary to study the growth of the ego and the super-ego—*i.e.*, to study the psychosexual development of the child. This consists of two phases:

1. The development of a mechanism to control and direct

[1] For a more detailed consideration of the infant's psychosexual development, see *The Psychology of the Infant*, by Siegfried Bernfeld, translated by Rosetta Hurwitz (New York: Brentano's, 1929); *Difficulties in Child Development*, by Mary Chadwick (New York: John Day Company, 1928); *The Sexual Development of the Child*, by S. E. Jelliffe, M.D., in Abt's *System of Pediatrics*, Vol. VII (Philadelphia: W. B. Saunders Company, 1923–26); and the numerous writings of Freud, Ferenczi, Abraham, and Ernest Jones.

the expression of id desires—*i.e.*, the genitalization of the libido.

2. The socialization of the genitalized libido.

THE GENITALIZATION OF THE LIBIDO

A. Birth.—At birth the child is a mechanism actuated by his instincts and capable of a considerable degree of reaction to both external and internal stimuli. He has been so for some time, but his environment has protected him from any need for reacting. Few, if any, external stimuli reached him (those that did probably facilitated the development of certain reflex patterns, but what these were are unknown in any given case) and his internal tensions were relieved almost before they existed. Without id tensions and hence without the need of activity to relieve those tensions, the individual apparently is in a state of complete satisfaction (lack of tension). Few or no physiological memory traces—*i.e.*, experiences that will color his future modes of reaction—remain of this period.

Birth changes this state suddenly and completely. From a tensionless state, the child becomes subjected to innumerable and unpleasant experiences which produce tension and need activity for their relief. The sudden change in environment exposes the child to stimuli—extreme pressure on the entire body, but mostly on the head, dry atmosphere, noise, light, cold, and above all lack of oxygen and increase of CO_2 due to pressure on and severance of the cord. Fortunately many of the sensory receptors are developed only to the point where they are affected by strong stimuli, so that the child is protected to some extent. These unpleasant sensory impulses, each of which is a threat to life, stimulate the instincts—particularly those of self-preservation. They also combine to produce a facilitated physiological reflex pattern, because the thalamus—the main organ of coördination of sensory pathways—is fully developed by the time of birth. The sensory cortex and intracortical pathways are not and, therefore, the child is not conscious of these experiences. Later, when the cortical development is adequate, a reactivation of the sensory component of this reflex pattern is felt as anxiety by the individual, and he attempts to flee from or to attack the source

of the stimuli because it is perceived as a threat to his existence.

Thus through birth the instincts in the id are stimulated. Their stimulation results in increase of id tension, to which the child reacts reflexly (by crying, breathing, etc.) and this increase of id tension and the need to do something to remove the discomfort of it are associated with a physiological pattern of anxiety. Hereafter, any increase in id tension will be felt as anxiety and reacted to reflexly, so that any situation that recalls the original experience, either because it threatens the physical integrity of the individual or because it symbolizes deprivation from some very comfortable and satisfying state—*i.e.*, because it signals the increase of id tensions—will reactivate the psychophysiological reflex pattern, producing the physical symptoms of dyspnea, tachycardia, sensations of pressure, particularly in the head, shivering, and so forth, and the emotional reaction of anxiety, and arousing an attempt at an adequate motor response. Birth, therefore, is the original situation which causes the individual to regard increased id tensions as dangerous and anxiety as the danger signal of such increased tensions. It is the individual's first traumatic experience and forms the pattern for the anxiety reactions which are such an important factor in his later psychosexual development.[1]

B. Nursing and Weaning.—During early infancy the situations that cause increased id tensions are largely internal physiological threats against the child's life (hunger, thirst, cold, heat, and so forth). This makes nursing a very important experience in personality development.

Some time after birth the sensation of hunger develops, and the child responds to the inner discomfort in the only way in which he is capable—by crying. This cry receives the attention of the mother, who feeds the baby. The intro-

[1] For a fuller discussion of this concept, see *The Trauma of Birth*, by Otto Rank (London: Kegan Paul, Trench, Trubner, and Company, 1929), and *Inhibition, Symptom, and Anxiety*, by Sigmund Freud (Stamford: Psychoanalytic Institute, 1927). Rank believes that the type of birth (duration and so forth) is the main factor in the production of the psychoneuroses. Freud believes that it has not this effect, but that it lays down the general reaction pattern of anxiety. The latter view is in harmony with the writer's own researches. See *The Problem Pre-school Child*, by G. H. J. Pearson, M.D. Graduate Thesis in Medicine, University of Pennsylvania, 1930.

duction of the nipple into the child's mouth stimulates the sucking reflex and also relieves tension in the erectile tissue of the lips. Feeding becomes not only a means of relief from hunger, but also a pleasurable experience because it relieves the "itching" tension of the oral mucus membrane. At first the child does not realize that the source of pleasure—the breast—is not part of himself. Therefore, when hungry or experiencing oral tension, he looks around for some source of relief and sucks his hand or foot, the bed clothes, or whatever is available. Gradually, as his organs of sensory perception develop, he comes to appreciate that he, his tensions and desires, are distinct from the things that relieve or increase them—*i.e.*, that he and the external world—a world that will not relieve his discomforts immediately and may increase them—are different entities. That is, his ego begins to develop. He learns also that the presence of his mother is usually associated with his pleasurable (relief from unpleasurable) feelings. Through the association, he transfers some of his physical pleasure to her—*i.e.*, comes to love her and want her.

Because of this close association of physical needs (self-preservative instinct) with pleasurable feelings (reproductive instinct) during nursing, the details of the process of feeding exert a highly important effect on the individual's modes of reacting. When a child's nursing experiences have been curtailed due to physical deformity of the mother's breast (too large or too small nipple, nipple lacking sufficient erectile tissue, etc.), some defect in the breast as milk-producing organ (too scant flow of milk, defect in the composition of the secretion, etc.), physical difficulties of the mother as a source of milk supply (illness, etc.), or too short a nursing period (because either of the mother's constitutional inability or her lack of desire to nurse the child), the child remains constantly unsatisfied and as a result develops the reaction pattern of always feeling slighted and wanting more. Such an individual will meet every situation with an underlying feeling that no matter how well things turn out for him, he will not get all that he deserves. Quite the opposite is the reaction pattern of the individual who has been nursed longer than the optimum time, for whom the supply of milk has

been overabundant and has flowed so freely that it required little or no effort on his part to obtain gastric satisfaction [1] or for whom the breast has been used as a ready pacifier for all outcries. Such an individual tends to go through life feeling that whatever happens, he is sure to get everything he wants with little or no effort. As Abraham [2] puts it, if he has no more than five cents to-day and no prospect of getting more, he will spend that five cents, perfectly satisfied that something will turn up to supply his needs to-morrow.

Throughout the nursing period, little or no curb is placed on the free expression of the child's desires, although the fact that the mother does take the breast away from him periodically, periodically allows him to suffer hunger pains and oral tensions, and does not attend to him immediately or foresee his discomforts before they develop has brought about two of the most important early steps in development—the realization that he is a separate entity in his environment and that reality will not permit the immediate satisfaction of his desires. The periodical withdrawal of the breast also keeps slightly active the anxiety pattern, each withdrawal symbolizing a possible permanent separation from the mother, who stands for life and pleasure to him. (For throughout the first year of life, because the child's world consists almost exclusively of himself and his mother, because she is the person who does everything for him, relieving his tensions and discomforts, he comes to regard her as the sole source of pleasure and life—*i.e.*, his sex instinct is directed toward her.) The recurrent reactivation of anxiety, with its threat of deprivation, desensitizes the child to some extent to situations that carry such a threat. This slow desensitization prepares him to tolerate the further steps in development, such as weaning—steps that carry such threats to a much greater degree and result in his learning *himself* to control his infantile desires, so that the instinctual urge may be expressed more in accord with the *mores* of the social organiza-

[1] Levy thinks that though the gastric tension (hunger) may be easily satisfied by an overabundant supply of milk, the oral tension is not, because the child does not suck long enough at a time. This lack of relief of oral tension causes the child to suck non-nutritive objects and so is one reason for the prolongation of finger-sucking.

[2] See "Psychoanalytic Studies on Character Formation", in *Selected Papers*, by Karl Abraham. London: Hogarth Press, 1927.

tion. They result also in his giving up the use of non-genital bodily zones—oral, anal, and urethral—for the expression of his sex desires.

The withdrawal of the breast periodically after nursing and the weaning procedure keep active the anxiety pattern of the child formed at birth because they both signify separation from the source of all pleasure (removal of unpleasure) and satisfaction. As such, they are a needed step in the process of growing up, which consists in the giving up of infantile sources of satisfaction and their replacement by more mature forms of activity. The control of these first steps lies in the hands of the mother; the manner in which she nurses the child prepares him for weaning and the manner of weaning for the next steps in development. She may carry these out in such a manner that they reactivate too markedly the anxiety pattern and leave the child ill-prepared for further progress. Or she may bring them about so easily that the child does not learn to face anxiety and so, because he has not experienced it to a sufficient degree, is not ready to face the sudden increase accompanying the next steps in progress.

The first three deprivations undergone by the child—birth, periodical separation from the mother after nursing, and weaning—tend to develop his ego—*i.e.*, his awareness of himself as distinct from the external world. They also produce certain reaction patterns in the child, and it is quite evident that such habitual modes of reaction will color an individual's behavior in any given situation. These deprivations are passive, so far as the child is concerned. He is born without his consent, and the breast is removed without his consent both periodically and permanently.

C. Bladder and Bowel Training.—The next step, learning to control bladder and bowels, is one in which he must coöperate, and after the weaning period is over, he is physically able to do so. Before this, such coöperation was impossible because the pyramidal tracts had not developed sufficiently to exercise voluntary control over the spinal reflex centers. Great harm may be done to the child's personality make-up by instituting training in cleanliness too early, because he is being asked to do something of which he is incapable physically.

Heretofore he was passive in his deprivations. Now he is asked to control himself, to withhold his urine and feces at one time and to give them up at another at the behest of the person whom he desires to please. He cannot have the pleasure (relief of unpleasant tension) of emptying his bladder and bowel when he likes and he must give up (lose) part of his body—his urine and feces [1]—when his mother desires it. He must deprive himself of his pleasure or of part of himself in order to remain pleasing to her.

Thus the child is torn between two desires. If he displeases his mother, he fears losing her, with the anxiety that entails. If he foregoes his pleasure (relief of unpleasure), he suffers discomfort. He tends to choose the activity that produces the least anxiety and internal discomfort—that is, he conforms to his mother's desires. In this he has begun to learn himself to control the infantile mode of expression of the sex instinct. The attempt to train bowel habits centers the child's interest on these activities as training in bladder control does on the genitals.[2] Any one who has observed a very young child has noticed the importance the child attributes to bowel movements for some time afterward.

In this way this earliest voluntary deprivation is the prototype of the majority of the subsequent deprivations the individual must undergo in the process of growing up. He must put aside immediate physical pleasure for a deferred end. There is a gradual rate of progression in his ability to do this. First, he controls himself by the mother's constant watchfulness. Soon he comes to understand from her actions that she expects him to relieve himself only at certain times and that she is pleased (loves him more) if he conforms. Later, he is able to control himself if she is near him and, still later, to do it even if she is not in the house. Even at this stage, however, if he is separated from her for several days, his control lapses, to return when she returns. This is observed quite commonly among placed children. A child who

[1] The feeling that bodily excretions are part of the individual, and as a result can be utilized by an enemy to work harm to the total person, is widespread among primitive peoples. In this their thinking and that of the infant are identical.

[2] See "A Note on a Process in Civilized Children Tending to Center the Libido on the Genitals", by G. H. J. Pearson, M.D. *Psychoanalytic Review*, Vol. 15, pp. 239–41, April, 1925.

has learned cleanliness will lose this control after separation from his mother and placement in a foster home, regaining it only when the foster mother has come to assume the same love relationship to him that the mother had. Even at this time a change to another foster home will often cause a recurrence of the same circle of behavior. It would seem that at first he tries to obey his mother's desire, but can do so only if she be present. Later he has incorporated her commands within himself, but needs her physical presence to reinforce them; and still later, the incorporated commands of the mother exert their influence in the mother's physical absence.

This is important because the mother's incorporated commands become a highly important part of the child's psychological make-up and form a definite factor to which he continues to react. If the deprivations of birth, nursing, and weaning have enabled him to recognize himself as a separate entity (ego) and have taught him that reality (environment) will not permit him always the pleasure of the direct and immediate satisfaction of his desires, training in bowel control forces him to control his infantile desires at the command of some one else—at first because she wants it, later because he wants to do it to please her. These incorporated parental commands form the nucleus of that part of the personality (the super-ego) which reinforces the individual's control over his infantile desires by the use of such concepts as "must", "ought", "must not", "ought not". In later life this nucleus develops into an internal conscience, with its codes of morality, cleanliness, ideals, etc. Often these codes are as clearly at variance with the actual realities of existence as were the mother's commands, for she often corrected the child because at the moment his accident or his refusal was irritating to her, regardless of whether he was at fault for his inability to conform. He has to learn to control himself at her unreasoning whim and thus throughout life may continue to control himself at similarly unreasonable dictates of certain codes and ideals and to feel that he has sinned if he transgresses them. The importance for character formation of the methods utilized for bowel training are evident from these considerations.

Although the child has to learn to control himself, he does

so at his mother's behest; therefore, the methods she uses are of great importance in the formation of his super-ego. If the mother considers this training as extremely important, the child will imitate this attitude. To the ordinary interest in the phenomena will be added traces of the importance attributed to them by the mother. He will feel that the way for him to be most acceptable to her will be by interest in bowel activities. As the next step in development is the relinquishing of the sex interest in excretory activities, such an individual will be unable to take this step; his interest will remain centered in excretory phenomena and his sex energy will be discharged in gastro-intestinal functions—that is, his libidinal development will be fixated at this point.

If the methods of training are severe—punishment for failure or expressions of disgust by the mother—the child will feel the need to conform to her standards to rid himself of the anxiety her attitude causes. He will fear that she will leave him unless he controls himself immediately. He takes over her attitude, and henceforth to him any semblance of soiling—not only bodily excretions, but all forms of muss and disorder—will be disgusting. Such a person becomes an extremely over-conscientious and over-meticulous individual.

If he is unable to control himself, he may develop the feeling that he is a failure and has lost his mother. Consequently, he prefers not to add to his anxiety the discomfort of controlling himself. As a result of his failure to control himself, the mother redoubles her efforts and the child finds the soiling a good way of attracting her interest (affection), which he is losing by the soiling. Here the latter mechanism prolongs the soiling and the punishments become pleasurable, partly because they are accompanied by the mother's attention to him, partly because they relieve him of the responsibility for soiling—*i.e.*, if he soils and can't help himself, he is punished; therefore, because he is punished, he is absolved from guilt and can revert to the infantile and more pleasing phase of existence, the emptying of his rectum whenever he feels inclined. This type of reaction—clinging to infantile modes of behavior through the permission given by punishment of some mild sort—may continue throughout life as a behavior pattern, even though soiling itself disappears.

Again, if the training be severe, the anxiety may cause a valiant attempt to accede to the mother's demands. As a result, the child will be clean, but will attempt to be clean always—*i.e.*, to retain his feces, refusing to give them up at the mother's demands. He does accede to her demand for cleanliness and so lessens his anxiety, but he subtly defeats her purpose by retaining the fecal mass when he should evacuate it. The mild pressure of retained feces is pleasurable even in adult life and consequently he also receives pleasure by retaining it. The mild constipation that ensues is translated psychologically into a sense of power. He does not have to give up anything he does not want to because training has laid emphasis on not giving it up. He becomes stubborn, is inclined to hoard things, and attains his ends through passive resistance.

It might be noted that perhaps no child needs active training in bowel control. By the time his pyramidal tracts can function and make possible voluntary control of the lower centers—about the time he starts to walk—the child is endeavoring to imitate all adult activities. If a little before this time regularity in toilet habits is observed, without any maternal reaction to failure, but with some slight praise for success, he himself will endeavor to be grown up and behave as adults do, and will quickly and easily attain habits of cleanliness without the adult centering of undue importance on them so harmful to his psychological development.

It would seem that the child first experiences pleasure through its oral region during nursing, later through bowel activities during bowel training, and still later through urethral activities during bladder training. This centers the child's interest in his genitals, which are the physiological organs for the sex instinct. His first eighteen months are devoted to the physiological process of the localization of the sex instinct in the genitals, and the processes involved, leaving as they do a deep physiological imprint, lay down certain behavior patterns which influence his reactions throughout the remainder of his life. He continues to react in these ways whenever he encounters a situation that involves reactions resembling the reactions of his parents—reactions that have become an integral part of his personality—at that time.

During all this process, he has been dependent entirely on his mother. She has been the one source of comfort and relief. To her has been directed all his feelings of affection. Up to the time of the localization of the libido [1] in his genitals, he has been able to obtain physical satisfaction from her and to do things physically to please her. Now he is beginning to feed himself, to walk, to attend to himself, and he does not get the same bodily satisfaction from her ministrations. Furthermore, there is no needful reason for his libidinous desires, localized in the penis, to get physical relief from her. He gets some relief from masturbation, which he begins to practice while bladder training is in progress. As Rank says, the libido is carried from the mouth (thumb-sucking) to the genitals by the hand (masturbation). He feels sex strivings in his genitals when he is in contact with his mother, and although he is not aware of the method, he knows he would like to get relief from this through her in some way. He has attained adult sex feelings without the knowledge of what he feels or without the capacity to gratify them, and the object toward whom his feelings are directed is his mother.

This first period may be described as that during which the sex instinct—the pleasure feelings—become localized in the genitals. This is a very necessary step in the growing up of the individual in order that he may be capable of fulfilling his biological aim—the reproduction of the species. During it the parental, usually maternal, commands—are incorporated into the individual as his super-ego and as a result certain deep-seated modes of reaction are formed which will furnish the basis for the individual's future behavior.

During this stage he is dependent entirely on the mother and his great source of anxiety is his fear that he may lose her. Because he is dependent on her, because she stands as the source of life and satisfaction (relief of tension), and because she institutes, or he institutes at her behest, certain deprivations that reactivate his birth-anxiety pattern and

[1] The biological aim of existence is the reproduction of the species—*i.e.*, the expression of the sex instinct. To this all other so-called instincts—self-preservation, etc.—are subsidiary. The physical organism produces energy for the service of this instinct and this instinct energy is known as libido. The release of libido is pleasurable—*i.e.*, reduces the discomfort of id tensions due to the accumulated sexualized energy.

that make him feel uncomfortable because they threaten his main instinctual drive—the sex instinct and its all important corollary, the instinct of self-preservation—her attitudes, her real feeling-tones toward him are of infinite importance in his development. Her own personality reactions, her urges, and her difficulties are reflected daily in her handling of the child.

It is a common observation that nervous primiparæ have irritable children, because of the uncertainty with which the inexperienced mother handles the child, which uncertainty is felt and reacted to by the latter. Of greater influence is the mother's underlying feeling toward the child as a symbol of what he represents in her life. She reacts also not only to the total present situation, her marital, social, and financial conditions, but to these conditions in the light of her past experiences, and the child becomes a part of this total situation and is reacted to as such. If she does not want the child, has no real love or affection for him, he will not only sense this attitude through her handling of him, but will feel it very markedly in the way she institutes training methods. To the real anxiety activated by the deprivation of training will be added the recognition of the mother's rejective attitude, so that instead of each deprivation being a point of departure in progress, it will be over-reacted to and will exert a definite and undesirable influence on the child's character—his fundamental modes of reaction. Furthermore, his development may become totally or partially arrested in one of the stages—oral, anal, or urethral—and the child, instead of being able to face the next step—that of socialization of the genitalized libido—will have to attempt to socialize an ungenitalized or partially genitalized libido, which is almost impossible, forcing him to attempt a step in growth for which he is not ready.

A similar situation occurs if the mother attempts to compensate for dislike of the child by undue protectiveness and care. Although on the surface she may seem a very good mother, the child feels the effect of the underlying unconscious attitude in her training procedures. On the other hand, if the mother is over-affectionate—*i.e.*, if the child represents to her all that is worth loving in life—she will make the early

periods too comfortable and the deprivations too easy so that the child, although comfortable at this period, will feel the full force of the anxiety factors in the next stage without having built up any immunity to them. If the child of the rejective mother has suffered such accentuations of anxiety that he is too sensitized to be able to withstand the anxiety-producing situations of the next stage, the child of the indulgent mother has experienced too little anxiety to withstand the same factors. The end result in both cases is similar—an overwhelming of the child, with inability to make progress and the development of a maladjusted personality.

THE SOCIALIZATION OF THE GENITALIZED LIBIDO

A. Relations with Parents.—The first period in development consists in the child's learning to give up infantile modes of expression of his instinctual desires and the use of those bodily zones that served as the means for this expression. As a result the period comes to an end when the sex energy is directed away from the oral, anal, and urethral zones and toward the genitals. The sex aim is still directed toward the mother; she is the child's first love.

The second step in development is that of the socialization of the libido, the stage in which the child turns his sex aim away from the mother and extends his contacts from within the family group outward, expanding his capacity to adjust to the social organization until he is a mature adult, able to reproduce his species in accordance with the dictates of the social organization in which he lives. This is a prolonged, complicated process because it involves so many factors and experiences, but it really is only apparently so, because the activities of the latter part of it are the results of the experiences of the first and early part of this second stage.

This second stage starts with a genitalized libido directed toward the mother. She is the first love object and remains the prototype of all future love objects. This infantile aim of the child has to be relinquished in order that he may choose a love object outside the family. Once again he has to learn to control the expression of his desires, giving up one source of satisfaction and replacing it by a different one. This is the most difficult adjustment he has to make and his success

in it determines the degree of his later adjustment. As Freud says, this is the nuclear complex of the neuroses.

By the beginning of the second stage, the young boy is old enough to perceive that he has to share his mother with a rival who has meant little to him during the early part of the previous stage—the father. As he observes, through the greater intimacies permitted the father, that the father is more pleasing to the mother, he endeavors to imitate him. He takes his father as his ideal—*i.e.*, incorporates his father's characteristics as part of his super-ego. Perfect imitation is an impossible task because the father is so much stronger, bigger, more capable—so much so that he is awe-inspiring—and despite the endeavors of the child, the father still retains the preferable relationship. Frustrated by this inability to rival the father, the child feels resentment and hatred. Because the father is so powerful and because the child really loves him, although he at the same time hates him, he daren't express his hate openly. Instead, it appears as fear and the fear is enhanced by the father's awe-inspiring qualities—rough face and hands, harsh voice, and so forth. As a result of this fear and of the child's real affection, he dare not be a rival for the mother's love. He fears that if he does display his affection for her, the father will punish him by removing the organ in which the child has the desire for the mother—the penis; *i.e.*, he will lose his mother by losing a part of himself. The presence of the mother arouses id tensions which are felt by the ego as anxiety because his super-ego (incorporated father ideal) will punish him if he expresses sex desires toward her. The anxiety is based on his previous deprivations and is again an overwhelming reactivation of his birth anxiety. In order to still the anxiety it becomes necessary for him to suppress his sex feelings and after a period of struggle he does so, at about the age of two to four. This is an interesting period because the evidences of the struggle are present in the average child's behavior and there is also a definite increase in the number of behavior problems.

B. Relations with Siblings.—The child cannot relieve his anxiety by suppressing his sex desires, but he does so by changing the object by which they are aroused, so that with

the suppression of the direction of his sex desires his interest is turned away from the family group and directed to the outside world. Heretofore his environment has consisted solely of himself, his father, and his mother. Now other people enter the circle of his activities. The most important, of course, are his siblings, although they may have been present and he aware of their presence for some time.

The much older sister may appear to him in a maternal rôle and because he will feel less threat from his father in love for her, she may come to occupy the relation that he desires with his mother. This is enhanced by the practice some parents have of allowing brother and elder sister to sleep together. The elder child, fired with sex curiosity, indulges in sex play with the brother which is gratifying to the latter, but raises a very serious conflict in his mind. Young boys frequently express the desire for sex play with their sisters. As one young boy expressed it, "I would like to play this game [masturbation] with my sister." The attitudes and behavior that the child develops toward his mother may be carried over completely in his attitudes and behavior to his older sister.

The older brother may absorb the attributes of the father and the boy will react to them as if he were the father. It is, however, easier to express hate toward the brother than to the all-powerful father, and the consequences seem less serious. This is perhaps the cause of the antagonism and quarreling that develop between a younger and an older brother. In the study of adult psychoneurotics and socially maladjusted individuals, the patient will often talk at length of his relations and feelings toward his siblings, and not until much later will he associate those same feelings with his relations with his parents. Not only can one see from these cases what took place earlier in the patient's life, but observation of children reveals these attitudes toward the parents in process of being shifted to the siblings.

If the younger child tends to project parental attributes on to the older siblings, he tends almost always to feel jealousy toward the still younger children. No matter how well prepared the child may be for the birth of younger siblings, the increase of antisocial and irritating behavior, slight as it

may be, following the birth indicates the underlying jealousy. If the relationship between the particular child and the parents is a healthy one, these manifestations disappear, to be replaced by parental attitudes toward the baby. Under this attitude lies a small portion of jealousy which may appear at any time that the individual's relationships become unpleasant. Certain children display this parental attitude to the younger children to an extreme degree; they become little fathers and little mothers. The extent of this reaction is in direct ratio to the depth of the underlying jealousy. One woman who had a very maternal attitude to her younger sister, but whose entire adult life suffered from her pangs of jealousy toward every one with whom she was associated, remembered that shortly after the sister's birth she tried to kill her by turning on the gas. Whether this act was real or phantasied matters little, because the underlying wish was present. Other children are actively hostile and try to injure the newcomer, their hatred showing itself in various ways, ranging from active and expert attempts to injure and hurt to an attempt to take the baby's place by demanding a bottle, the baby carriage, the baby's bed, and so forth. Probably it is the reflection of this attitude by the older children that causes the younger to project onto them their feelings about their parents.

C. Ordinal Position in the Family.—The reactions that occur between a child and his siblings indicate the important effect on the child's personality development of the ordinal position in the family. An eldest child tends to feel cheated and deprived of his place by the younger. He feels the need to strive constantly to maintain his position, and if the younger should be brighter or more competent in any way, the elder may find the struggle too hard and give up. This giving up is fostered by many parents who make the elder always give into the younger, so that the pattern of giving in becomes an habitual mode of reaction. Oldest children thus suffer under a slight handicap all their lives. If the older is a boy and the younger a girl, the former's difficulties are increased because the latter matures faster. The second child has the elder as a pacemaker. He strives constantly to do and be as competent as the elder appears to be as a result of the latter's age, greater experience, and strength.

Constantly comparing himself to his own disadvantage with the elder child, he strives to reduce the inequality by excelling in an entirely opposite way—if the elder is the good child, the second may be a very bad one, or *vice versa*—or by appropriating the elder's sources of satisfaction, friends and so forth. One second child said that the first words of her sister were, "Can I have some tea?" and her own first words were, "Me, too." Her behavior ever since has amplified and enlarged this type of behavior. The younger child who tags along after the elder, wishing to take part in all the latter's activities to his great annoyance, is too well known to require exemplification.

The middle child is in a particularly difficult situation. He must strive to equal the elder and keep in advance of the younger. Paternal affection is often bestowed more on the eldest and the youngest (the eldest son, the heir; the youngest, the child of old age) so that the middle child gets a scantier amount of affection. The youngest child is notoriously babyish because the parental attitude is usually over-indulgent. The only child has two sources of difficulties: one, the fact that he is exposed to the undiluted force of parental attitudes; the other, that he experiences an undiluted reaction to these attitudes—he cannot project his feeling about his parents onto sibling substitutes.

D. Latency.—The formation of the personality—the basis for the individual's habitual modes of reaction—occurs during the pre-school period. During this period the child is reacting to his environment, which consists of the family group, primarily the mother and father and secondarily their immediate surrogates, the other children. For the young child of either sex, the first stage consists of the physiological events that determine the genitalization of the libido. Following this comes the stage in which the libido becomes attracted to an object; for the boy this is the mother, for the girl the father. If the libido has been adequately genitalized through the influences of mature, well-adjusted parents, the child next has to undergo the process of repression of desire for the parent of the opposite sex.

This is a struggle in every instance, but again, if the parents are mature individuals, their attitudes enable the child to

pass through this stage and enter the period of latency. This extends from about the fourth year to the pre-pubertal period. During this period sex desire is suppressed and the energy of this instinct is used for acquiring knowledge. It is perhaps an unconscious realization of this that has set the legal requirements for school entrance about five years of age, because before this the energy is devoted to the expression of the sex desire and its repression. Perhaps the fact that a child seems to make little progress if he is sent to school too young may be based less on his intellectual incapacity than on the fact that his energies are devoted to his internal struggle with his sex instincts.[1]

During the period of his struggle with his sex instinct, the young child tends to be solitary in his play. With the development of the period of sexual latency, he begins to be more social, usually playing more and more with his own sex. His repression of his sex desire for the parent of the opposite sex turns him from any object that resembles her (has the same sex), but as all sex energy cannot be expended in altered, sublimated form, some still seeks a human object and finds it in children of the same sex and age. Although love for the parent of the opposite sex and hatred of the parent of the same sex is repressed and becomes unconscious, it still shows its presence in the child's play. In this the boy tends to direct his hostile impulses—the most difficult to suppress—playfully toward his playmates, in such surprise-and-attack combative games as cops and robbers, cowboys and Indians, and so forth. In this mimicry he works off the energy of his real desires—to kill, injure, and despoil the parent of the same sex—so that his internal tensions are lessened and he is able to repress his desires more effectively. The little girl tends to play with dolls, to play house, and so forth. Through such play she realizes her desire to displace the parent of the same sex and remove her from existence.

During the period of latency the child enters two new

[1] Children who are in the throes of an emotional conflict do very poor school work. In fact, both from observation and from tests, they may appear feeble-minded. It is not unusual to find a psychometric examination give a low rating in such a child while a later one, after the emotional conflict has been resolved, results in a much higher score. This raises the question of the advisability of nursery schools. Perhaps they are requiring the child to make social and other adjustments before he is psychologically ready to do so.

situations in which he has to depend on himself—at school and with playmates. His ability to enter these situations will depend on the degree to which his libido has been genitalized and the extent to which he has satisfactorily repressed his sex desires. His reaction to the teacher who stands for authority (the father) and whose favors must be shared with other children (the mother) will depend entirely on the modes of behavior he has developed through his relations with his parents and how these relations have enabled him to handle his desires, loves, jealousies, and other manifestations of the sex instinct. Similarly his attitude and relations with other children will depend on the degree of success he has had in repressing his conflict about his parents; that is, as the siblings stand to him as parent surrogates, so the other children are sibling surrogates—*i.e.*, parent substitutes. His success in school will depend not so much on his innate intelligence, important as this is, as on the degree of energy freed for the acquisition of knowledge by a successful repression of his conflict about his parents.

His personality—his habitual modes of reaction—are formed by the time he enters school. Henceforth he reacts to external situations as if they were replicas of his infant situation. The father, at first a concrete person, tends to become more abstract and his attributes—authority, punishment, and so forth—to be attached to other individuals who hold a similarly dominating position. His reactions to the latter are the same as his early reactions to the real father. He continues to react to all love objects as he learned to react to his mother, their prototype.

E. Adolescence.—The latency period ends and the next stage, adolescence, begins with the pre-pubertal period. Several years before adolescence, the rate of physical growth and activity of the sex glands—which have decreased since the beginning of the latency period—show increased activity. This is associated with a recrudescence of the manifestations of the sex instinct, particularly in the individual's attitude toward love objects (those of the opposite sex). The expanding energy of the sex instinct comes into conflict with the repressing forces, for these forces have been developed entirely against this instinct energy since the institution of

their early nuclei—the deprivations of nursing, weaning, and bowel and bladder training. The repressing forces (super-ego) have been effective enough during the decreased sex activity of the latency period, but are not so effectual against the strong tides of sex energy that set in now. Consequently nearly all the energy at the disposal of the individual is devoted to keeping the sex energy in check. Energy so bound leaves little free for the daily occupations of life and only a small amount to spare for coördinating and associating the great influx of sense impressions that are entering the individual because of the increase in sensitivity of the sensory receptors. As a consequence of this internal struggle, the adolescent seems to lose his intellectual capacity, and often the brilliant child begins to fail in school or to seem mentally defective. This is a common experience of teachers who work with the sixth, seventh, and eighth grades. And it is their experience also that the children in these grades tend to present the greatest number of educational and social problems. Often lack of understanding of this phenomenon by teachers and parents and their concern over the trends they see in the child add to the tension of the latter's internal struggle the feeling that adults are unreasonable or hostile.

During this period the repressive factors are not able to suppress the sex urge and so devote their energies to a deflection of its aim—namely, away from the members of the family toward individuals who are not blood relations. For a short while the issue hangs in doubt. Will the repressive forces prove too strong for the sex urges? If they do, the libido retreats from its point of genitalization to early forms of bodily satisfaction—anal, urethral, oral. This is true to some slight extent in nearly every adolescent, as is shown by the increased interest in dieting food fads, increased attention to bodily care, and so forth (which interests are rationalized as needful to develop a good physique), and by an occasional attack of enuresis. Ordinarily, no more regressive signs than these are present, but if the early development of the child has been hindered so that the genitalization of the libido was not accomplished in an adequate manner, the greater part of the libido returns to the point where the hindrance of development occurred, and the sex energy, instead of flowing outward

toward the world, becomes centered in the individual, with the development of traits of seclusiveness, lack of interest in the outside world, and gradual withdrawal from and denial of reality—the first symptoms of schizophrenia which notoriously tends to begin during adolescence. If the repressive forces are less punitive and the libido has been genitalized adequately—for one process is the complement of the other—the aim of the sex energy may be deflected from the outside world to the individual's genitals. This is seen in the almost universal practice of adolescent masturbation. Again, if the repressive forces are not too punitive and there has been an adequate working through of the conflict about the parents, this stage is but transitory. If, however, the attachment to the parent of the opposite sex has been so great that any sex impulse directed outward is toward that parent and so comes under the ban of the fear of the other, the only solution for relief of sex tension is by masturbation. The individual becomes unable to develop a heterosexual adjustment and a satisfactory marriage is impossible.

If the repressive forces are overstrong, highly punitive, they are directed against any manifestation of sexuality. This occurs to a slight extent in all adolescents and the unfamiliar feelings within the body are struggled with through increase in activity—athletics and so forth, increased interest in school work (with its real goal—withdrawal from social contact and consequent lack of sex stimulation), or by depression, moodiness, outbursts of anger, and so forth. Frequently the anxiety aroused by the struggle between the repressive forces and the sex instinct is symptomatized by weird fears—fears of the end of the world, of eternal punishment, of death. One woman stated that when she was twelve, she felt a strange, sinful feeling within herself which was so strong that she was unable to sleep for days and spent most of the night walking the floor and praying that she be delivered from temptation. Her school work, social adjustments, and general efficiency suffered proportionately. She found peace only in religion, where the concept of God reinforced the power of the repressive forces until they were more powerful than the sex urges. Needless to say the sexual side of her marital life and her attitudes to the exhibition of slight sex manifestations are

suffering at present from the heightened efficiency of the repressions.

The goal of the repressive forces in the average adolescent whose pre-adolescent development has proceeded normally is to deflect the sex instinct away from the members of the immediate family. With the onset of adolescence, the sex urge again is directed toward the parent of the opposite sex with associated hostility to the other. The adolescent has to remain in the home. He has to be associated with his parents, and they, usually unable to perceive that the baby of a few years ago is now an adult, try to give him the same interest, attention, and care they gave to the much younger child. Their affectionate attitude and close proximity increase the sex desire toward them. This comes into conflict with the forces of repression and increases the child's need to get away from his parents. He cannot withdraw physically. He does so emotionally by developing behavior which is an expression of antagonism to the parents and by transfering his loyalties and affections to adults outside the family—the well-known hero worship and crush. Often he transfers his loyalties to adults whose points of view are opposed to the views held by his parents, and the result is constant bickering between parents and child. This bickering serves a second purpose. It enables him, first, to satisfy his repressing forces which he is turning away from the parents, and, secondly, to occupy the center of the parents' interest through their worry and distress and constant reiteration of their annoyance at his attempt to demolish their cherished ideals. Thus by bickering the adolescent retains his desire for his parents, receives sufficient punishment (unhappiness and discomfort) to appease the repressing forces, and at the same time by appeasing them sanctions his further attachment to his parents.

The adolescent is really in a very difficult situation. He must break with his parents—*i.e.*, his sex desire must turn from them to individuals outside the home. In doing this he tends to accept the ideals and points of view of his social group. Differing as such points of view probably are in a highly individualistic and complex society like America, his adherence to them probably means that he must discard many of the highly cherished ideals of his parents. They resent this

because they feel that their experience has proved the value of these ideals and they wish their child to learn from them rather than suffer the pain involved in learning from experience and to carry on their traditions and ideals as he will carry on their race. Thus the break with the parents entails much suffering for the child.

On the other hand, if he clings to his attachment to his parents, he suffers both from the punishments instituted by his own super-ego and from the ostracism he will receive at the hands of his companions. Again there is a conflict, with suffering for the child. Such conflicts and suffering are the lot of every adolescent, but their depth, severity, and termination depend on the power of the repressing forces (developed in infancy), the mobility of the sex urges (dependent on the adequacy of development during the pre-school period), and the actual attitudes of the parents. If the parents are moderately well adjusted and the developmental process has been adequate, the conflicts and unhappinesses of adolescence gradually disappear, the instincts become directed to individuals of the opposite sex and the same age, and the antagonisms and conflicts with the parents disappear. In fact, the individual usually accepts to a greater or less degree as most desirable the parents' attitudes and ideals, because those ideals really became a part of his unconscious personality through imitation of the parents in the first few years of life. The individual now, through marriage, vocation, and so forth, sets up a new unit for the adequate and socially acceptable utilization of the sex urge—the reproduction of the species.

FACTORS HINDERING PSYCHOSEXUAL DEVELOPMENT

The biological aim of life is the reproduction of the species. The creative energy at the service of this instinct is far in excess of the actual needs. The superfluous energy has been utilized through long ages in producing the highly complex human physical organization, and through a shorter period of time in reducing the discomforts and dangers of the physical world—in building up our highly complex social organization. This highly organized physical organization and complex social structure place many obstacles between the sex instinct and its ultimate direct expression. The development of the

child consists in the control and direction of the sex instinct so that its aim may be accomplished in the most effective manner, both for the individual, the social organization, and the new member of the species that results. At first through the physiological reactions of living, the sex instinct has to be genitalized. In doing this the child has to learn to control the manner and site of expression of his infantile desires. He accomplishes this first by the help of his parents; then by developing a super-ego that takes their place. The aim of the impulse has to be centered on an object and still later must be deflected from the original object to a similar object outside the family group. In this the same mechanisms are used. During this process also energy must be available for use in acquiring the skills and knowledge needful for living.

Growing up, then, consists in the development by the individual, assisted by his super-ego, of the power to adapt the expression of his instinctual urges and infantile desires to the demands of reality. Any increase in power of the internal forces or deficiency in the development of the controlling forces produces a state of conflict that is recognized by the individual's behavior. The complexities of the physical and social structure call for a wide capacity for new adjustments in the individual, and this capacity depends on the amount of free sex energy at his service. Anything that tends to inhibit the course of development of the sex instinct tends to bind unusual amounts of energy and this reduces the capacity to adjust. There are probably two types of inhibiting factors. The individual may have some innate tendency to over-react to the pleasure of stimulation of one bodily zone—oral, anal, or urethral. Thus the sex energy is bound physiologically and the progression to the final zone—the genital—is made difficult or even impossible. Of much greater importance are the influences and attitudes of the parents. The mother or father who rejects or who indulges the child interferes greatly with the latter's development. In these cases the parents themselves are reacting to the child, not as a child, but as a symbol of some satisfaction or dissatisfaction in their own lives. They are themselves emotionally underdeveloped, and as a result cannot adjust adequately or happily to their life situation and seize on the child as a vent for their own internal conflicts.

The expression of their conflicts causes a hindrance in the child's development, with resultant disaster to the latter.

As behavior is the attempt of the individual to adapt himself to his environment, the child whose development has been inhibited cannot adapt himself adequately in the usual manner. His behavior then will differ—*i.e.*, be designated as a problem. If the inhibition occurs before the genitalization of the libido occurs, there is no free energy directed to the outside world. The capacity for adjustment is woefully inadequate and the sole solution is in withdrawing from the real world, denying its existence, and developing a world of phantasy which the individual can control. In other words, a psychosis develops. If the major inhibition occurs after the genitalization of the libido—*i.e.*, in the stage of conflict about the parents—the individual solves his conflict through neurotic or socially unacceptable behavior (delinquency, social maladjustments). This behavior is satisfying to him because it is the only way in which he can adapt himself, but it may be extremely unsatisfying to his environment.

Such is the course of the child's psychosexual development. Its purpose is to develop an ego and a super-ego that will permit expression of id impulses (and consequent relief of internal tension) in conformity with the dictates of reality. The ego endeavors to relieve such id tensions through the following methods:

1. By allowing direct expression as long as such direct expression does not produce parental disfavor.

2. By allowing direct expression, but directing the aim of this expression toward other objects. Thus the child may direct the hate and cruelty he feels toward the parent of the same sex toward other children, siblings, and so forth. This allows direct expression of id desires, but does not bring in its wake fears of parental disfavor, although some punishment may result. Or the child obsessed by sex curiosity may ask countless questions about indifferent matters, questions often of a silly and unanswerable type—why is the sky blue, the grass green, street cars yellow, and so forth.

3. By changing the method of expression so that it becomes socially acceptable. Thus the cruelty impulses may find expression in a spirit of scientific investigation; the child will

want to know how the wheels go round in the watch and take it to pieces to find out.

4. By attempting to close all outlets to a particular impulse or group of impulses.

The function of the internal conscience or super-ego is to warn the ego that id impulses are attempting to escape by undesirable outlets and to compel the ego to prevent this. The usual way for the super-ego to handle such a situation is to force the ego to close all outlets to a particular id impulse. This produces intolerable tension, so that the ego has to compromise between the two forces in one of the two following ways:

1. By allowing the id impulse expression in a form of behavior exactly opposite to that of its direct expression. A child who has a strong cruelty impulse behaves as if he were exaggeratedly tender-hearted and compassionate, or one who has a strong desire to play in dirt (with feces) behaves as if he were exaggeratedly cleanly.

2. By allowing certain aspects of the id impulses to be expressed directly and then seeking punishment for this expression, as in the two cases that follow.

A boy was consumed with a burning love for his mother. He feared to express his strong sexual yearnings for her because he felt that this would incur his father's displeasure. So he began to play with fire—setting a fire several times in his mother's bedroom. Playing with fire always resulted in punishment because of the mother's normal fear that the child would injure himself. The fire setting continued and became more serious. One day the mother decided not to punish him. As a result the boy's behavior became more and more difficult as the day wore on until he started to break the windows. After being punished for this, he behaved beautifully. The ego allowed the immoral id impulses (passionate sex love for the mother) expression in a symbolic form (building fires) provided he could be punished as a result to appease the super-ego. When no punishment was forthcoming, he had to obtain such punishment by fair means or foul.

An eighteen-year-old was a persistent thief. He stole at school, in his home, and from the store in which he worked. The parents had tried all forms of treatment—punishment, lectures, kindness, moralizing, all without avail. The boy

himself noted that he was invariably caught and that he seemed to steal in such a way that he would be caught. He described his stealing as consisting first of a feeling of uneasiness, then of a desire to steal, and later of a conflict over whether he would or would not steal. This would last several days. Then he would steal, be caught and punished, and feel better. He based his desire to steal on the need he felt for more money in his pocket than he actually required (the stolen money was seldom spent). He related this need to his feeling that he was inferior to others. Though he actually was large for his age, he expressed great concern over his height and size, exclaiming that he was so small and poorly developed. Later he related this feeling to concern over his small penis. Although he expressed great concern over his health, he took little physical care of himself. He explained that his physical condition, his stealing, and the size of his penis were sent on him as a punishment. It was quite evident that he suffered from a need for punishment (this explains his feeling of uneasiness preceding the stealing) and that he satisfied this need by stealing and getting caught and by neglecting all hygienic considerations—keeping late hours, eating improper food, and so forth. His need for punishment was the result of his unconscious attachment and sexual desire for his mother and hatred of his father. He dared not express these desires, lest he be punished by the father by castration. The small size of his penis kept this fear constantly active. Perhaps also it made him feel that he could continue his desire for his mother because a portion of the punishment had already fallen on him and so must serve to placate his father to some degree. Also, if he were punished for doing something that the father disliked, such as stealing, the father would be appeased and not notice the desire to steal the mother from him. Thus his punishment removed his anxiety and permitted him to toy with phantasies about his mother.[1] In such a case

[1] It must be distinctly understood that these mechanisms were unconscious. He was not aware that he desired his mother or that he hated his father—although he did express conscious resentment against the father because he seemed to favor another son. Neither was he aware that he feared castration by his father. He was aware that he was concerned about his physical health, his size, and the size of his penis, and he regarded all these things as a punishment visited on him for some wrongdoing. It must be understood also that it was not his real father he feared, but the father's incorporated image.

punishment, of course, only kept the mechanism active, for it gave the individual what he desired to enable him to continue his unhealthy phantasies.

In such cases the conflict is an internal one—*i.e.*, between the id, the super-ego, and the ego. It cannot be resolved by changing the environment or even by altering the attitudes of the parents because the child carries his internal conflict with him wherever he goes. The only really lasting and effectual treatment will be through psychoanalysis of the child himself along the lines first indicated by Freud[1] and developed by Melanie Klein[2] and Anna Freud.[3]

[1] See "The Analysis of a Five-Year-Old Boy" in his *Collected Papers.* New York: International Psychoanalytical Press, 1924–25.

[2] See her numerous articles in recent numbers of the *International Journal of Psycho-Analysis.*

[3] See her *Introduction to the Technic of Child Analysis.* New York: Nervous and Mental Disease Publishing Company, 1928.

THE FEELING OF GUILT AND ITS EFFECTS*

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THE feeling of exaggerated and seemingly unwarranted guilt has for many years been recognized as a prominent characteristic of manic-depressive depression. In more recent years Freud has shown that this feeling is also present in a variety of other conditions, especially the neuroses, and that the resultant desire for self-punishment is an important factor in the formation of neurotic symptoms.

According to Freud guilt feelings arise through the Œdipus complex, from the clash of incestuous cravings with ethical strivings. Guilt always implies a desire to be punished, which may express itself in a variety of ways. Thus a neurotic symptom, representing a disguised gratification of a forbidden craving, will at the same time tend to assuage a sense of guilt by inconveniencing—*i.e.*, punishing—the patient. In other cases the desire for self-punishment expresses itself more directly, as in criminals who commit crimes only when they are sure to be detected. (A colleague told me of a kleptomanic man who stole only large objects, such as trombones, bicycles, and so forth, so that invariably he was caught.) In still other cases one sees the wish for punishment expressed in "punishment dreams", in which the patient meets with some misfortune.

In view of the importance of guilt as a factor in human behavior, it seemed worth while to ascertain how it manifested itself in the general run of cases referred to the Psychiatric Department of the Community Health Center, Philadelphia. Most of the patients seen in this department are referred by the various agencies of the Federation of Jewish Charities. They include persons of both sexes and

* From the Psychiatric Department of the Community Health Center, Philadelphia.

all ages and present a variety of problems, such as undesirable personality traits, delinquency, marital maladjustment, and neuroses. Occasionally one meets with major psychoses, but they are rarely severe enough to require hospitalization. The one thing the patients have in common is that they are all, with rare exceptions, poor and harassed by economic insecurity.

Nine cases are here presented with manifestations of guilt. A number of other cases were excluded as not sufficiently instructive. It must be remembered that in no case did the investigation and treatment approach analytic intensity. Cases seen more than twenty times were exceptional. With more intensive investigation, guilt phenomena would undoubtedly have been discovered in a much greater number of cases.

In its simplest form guilt expresses itself in the desire to deprive oneself of the forbidden fruits of transgression, as in the following case:

Case 1.—A boy of eight was playing "parcheesi" with a social worker. On a number of occasions the boy cheated by slyly moving his counter more than the proper number of spaces. The worker finally decided no longer to pretend ignorance of his deception, and on the next offense she reminded him that he had moved his counter too many spaces. He thereupon took his counter back to its last resting point and then moved it forward a number of spaces *less* than was his due. The boy, in other words, surrendered a portion of his previous ill-gotten gains; he not only acknowledged the "mistake" which the worker had called to his attention, but he also atoned in part for previous thefts which (so far as he knew) had escaped her observation.

In the next case we see a "punishment phantasy" in a boy who hated his father and who, in the phantasy, deprived himself of an opportunity to be with his mother, who was at that time living alone.

Case 2.—Joseph S., born in April, 1921. The father deserted shortly before Joseph was born. The mother was a frail, neurotic little woman who became a semi-invalid following the birth of her child. For six years Joseph and his mother lived with various relatives; then, in January, 1927, he was placed in an orphanage.

Joseph developed into a bright, friendly, talkative boy. At the orphanage it was noted that he had an intermittent tremor of the fingers. He was conscious of this habit and said that he had "learned" it from observing a man "shaking".

Joseph's attitude toward his father is noteworthy. At the age of four, while he and his mother were living with her parents, Joseph

often overheard his grandmother urging his mother to take her husband back. The mother finally agreed, and the father was allowed to return, but he left again after a week. Soon after this Joseph was asked by his mother whether he would like his father to return again. Joseph replied, "If you like him, take him back, but he's nothing to me any more." He was then asked what he would do if he became wealthy and his father came to him for money. He replied, "I would give him money, but nothing else."

In May, 1930, Joseph related a recent phantasy: "My mother was going to take me home [from the orphanage] and I was putting on my clothes getting ready to go. Then the telephone rang and I learned that I wasn't to go home, and I had to get all undressed again. *This* [phantasy] *started out as something that I liked, but it ended as something that I didn't like.*"

For a boy to phantasy that he is leaving the orphanage is not unusual. On the other hand, to phantasy an anticipated pleasure and then to phantasy a last-moment disappointment is extraordinary. In interpreting this phantasy, we must not ignore the fact that Joseph hated his father. He hated him ostensibly for his unkindness to his mother, but this probably was only a rationalization of a hatred resulting from jealousy and consciousness of rivalry. Hatred so motivated is bound to lead to a sense of guilt. In the phantasy Joseph was about to leave the orphanage and go to live with his mother, thus gratifying a wish based probably on unconscious incestuous cravings as well as on the more acceptable sentiments of "mother love". The aroused sense of guilt intervened and prevented the consummation of the forbidden wish. Joseph himself was utterly unaware of the implications of the phantasy. His conscience, however, was not deceived by the incestuous cravings masquerading in the first part of the phantasy.

There is a certain similarity between this incident and that recorded in Case 1. The patient in Case 1 stole an advantage and then returned part of it. Similarly Joseph, in phantasy, started to gratify a desire that contained an element of the forbidden, but his conscience prevented its final consummation.

Case 3.—A young man of seventeen was the fourth of nine children. The father was a poor, shiftless man, and all the older children had grown to hate him, particularly resenting the fact that in spite of his chronic poverty he had failed to restrict the size of his family. The patient had the additional problem of sensitiveness over his poor physique. He drifted into a life of crime, going as far as robbery at the point of a gun.

The patient related two "punishment dreams":

1. "I was associated with a crowd of gamblers. There was a big race on, and I fixed a horse. I was the head of a vast organization of gamblers—which I hope will come true some day—and we fixed it so that this horse would win. The horse was running at 20 to 1, and I bet thousands of dollars and lost! I was bankrupt, and collectors came to my office on Chestnut Street and took everything away."

2. "I had a lot of money from the bootlegging racket, and I rented an apartment in the center of the city. I enrolled at a private preparatory school, where I was taught French and Spanish. I went there a year and a half, playing basket ball and other sports, and I never went home to visit my parents. Then I ran out of dough and quit school, and a policeman arrested me for bootlegging. They convicted me on my past record, and I got from three to seven years."

Here, as in Joseph's phantasy, we have two dreams which "started out good, but ended bad". Each dream began by fulfilling a wish to be a successful criminal—*i.e.*, a successful rebel against the authority of society and the father.

In the next case we see marked guilt feelings in a young woman who bore resentment against her mother, which, though justifiable, nevertheless provoked strong conflicts in her.

Case 4.—An intelligent young woman of twenty-four, the youngest of three daughters, was unhappy over the fact that her mother openly rejected her. The mother had always treated her like a stepchild, calling her the "black sheep" of the family, and so forth. While resenting this attitude, the patient nevertheless was disturbed by the fact that thoughts came to her over which she felt guilty. Thus, at night, while in bed waiting to fall asleep, "I see my mother in her coffin". She was often "afraid" that news might come of her mother's death; *e.g.*, when the telephone rang at the office, her first thought was that there might be bad news. She often awakened at night, fancying that her mother had died, and she had to reassure herself by listening to her breathing. Though she was in no way responsible for her mother's hard life (poverty), "I always have an uneasy feeling that I am the cause of my mother's troubles".

Once I accidentally had an opportunity to speak to the mother about another matter, after which the patient told me that she was glad: "I'm glad you had a chance to see that my mother is not as bad as I might have led you to believe." It is noteworthy that at the office where she worked, the patient often felt impelled to take the blame for errors for which she had in fact not been responsible.

In this case it is noteworthy that although the patient had ample reason to hate her mother, she did not do so—at least not on the surface. On the contrary, her attitude toward her mother was a most charitable one. She was glad that I had had an opportunity to revise any poor opinion she might

have given me of her mother. Although perfectly innocent, she had the "uneasy feeling" that she was the cause of her mother's troubles. Such "considerateness" suggests an attempt to compensate for a deep-seated hatred—a hatred that expressed itself in fancies that her mother was in her coffin, and so forth. This hatred probably did not originate in the mother's cruel attitude, but was aggravated by it. It was no doubt this hatred that gave rise to a sense of guilt, which manifested itself in an impulse to take the blame for things that were really not her fault.

We now come to five cases in which there is a definite relationship between guilt and more pronounced neurotic and psychotic symptoms.

Case 5.—Mildred F., aged nineteen, suffered from hysterical attacks for half a year. Significant for the present discussion is the fact that she was the only child of a very immature, helpless widow, and that in recent years her mother had resented her desire to break away: "She complained that I gave too much time to my girl friends. She felt I should be with *her* more."

The first attack occurred on a Saturday afternoon under the following circumstances. Mildred and a friend, Betty, were planning to drive out to the country in the car of a boy friend. Just before they left, the mother's employer (a woman) made her appearance. The employer was bound for the same destination, but her friends, who had promised to drive her out, had disappointed her at the last minute. The mother, wishing to ingratiate herself, asked Mildred to take the employer along in place of Betty. Mildred, however, did not want to do this. The mother became angry and said, "It's always Betty! You'd never do anything for me!" Mildred still refused, and the mother finally ordered, "Well, if that's the case, you're not going to go at all—you're going to stay home!"

Mildred coolly disregarded her mother and went anyhow, arriving in the country early in the evening. "As soon as I got there, I didn't feel good. I felt like my insides were all shaking." She went to a nearby store, ordered some aromatics, and sat outside waiting for it. The mother's employer, having in the meantime arrived in another car, came up and asked, "What's the matter?" Mildred replied, "I feel sick." "What's the trouble?" the employer asked. "I don't know", said Mildred.

"As soon as I said that, I started to moan and I slid to my knees. I was as stiff as a board. I couldn't move. They all talked to me and I heard them, but I couldn't answer."

This girl had her first hysterical attack a few hours after she had flagrantly disobeyed her mother. The mother had ordered her not to set out on the trip except under certain conditions, and the patient had disregarded her completely.

Having reached her destination—*i.e.*, having carried to completion her act of disobedience—she began to feel "sick". The mother's employer (symbol of the dispute) then happened to come up, which intensified the patient's conflict. While talking to her, the patient collapsed. It is likely that a feeling of guilt—arising from long-standing unconscious hatred and aggravated by the quarrel—was one of the precipitating factors of the first attack.

The next two cases deal with young schizophrenics.

Case 6.—Isaac L., born in 1908. The fraternity consisted of a brother, a sister, the patient, and two sisters.

The patient was always unusually quiet and lacking in boisterous spirits. He never participated in boyish sports; "he never climbed a fence". At the age of five he was enrolled in kindergarten, but refused to stay unless his mother stayed with him. On several occasions, when she actually left him there, he ran home at recess time. When she attempted to enroll him in elementary school at the age of six, he flatly refused. Indeed he did not enter school until the age of eight, during a one-year placement in a private foster home while his mother was away at a sanitarium (tuberculosis). Except for that year, Isaac was not away from his mother for a single day until he was placed on a farm in 1930.

Isaac developed into a morose, awkward young man. He was invariably the butt of teasing at factories where he worked. This was aggravated by his sex awkwardness, which was associated with unusual ignorance of sex and with strong homosexual leanings. His factory mates often took advantage of his awkwardness and his poor sense of humor, challenging him, for example, to demonstrate his penis in order to prove, as they said, that he was not a masturbator. Isaac always complied, not realizing that this would only perpetuate the urge to tease.

Isaac complained (in 1929) of subjective difficulty in thinking, "When I think a lot, that puts me in a daze. . . . My ideas run away like the wind; they just last a second and then good-by. . . . I haven't got a good brain to remember things." He also spoke of auditory and visual hallucinations.

Isaac's relationship with his father is of special interest. The father died in 1927. According to the older sister, Isaac as well as the other children was deeply devoted to the father. They loved him because he was kind, and "held him in awe" because he was firm with them. As the sister said, "One look from him was enough to make us stop misbehaving." The father worked in a noisy factory and craved quiet when he returned home in the evening. The children were, therefore, not allowed to speak during the evening meal, since if they once began to speak, they would soon be raising their voices.

After the father's death, Isaac became more melancholy than before. He showed a desire to step into his father's shoes in certain respects. To quote the older sister (1929), "Isaac thinks he's the boss of the family, being he's the only man there. [The older brother was married and lived elsewhere.] He seems to feel, 'Being Pop isn't here, I'm the

boss.'" In rather pathetic fashion, he attempted to exercise his authority. Thus he attempted to dictate what clothes his younger sisters should wear, what young men they should go out with, and so forth. His older sister (married) was rather active and jolly, which Isaac regarded as unseemly for a married woman.

Isaac showed great reverence for his dead father. He spoke of him frequently. His father left some old Victrola records, which in the course of time the family wanted to dispose of. Isaac, however, insisted that the family keep them as a remembrance. Similarly the family wanted to give away the father's sacred Hebrew books to a pious and venerable relative, but again Isaac refused his permission.

At an interview in 1930, after telling me how hard it was to find work, Isaac said, "My father died, *and I don't see why I should be punished for it.* I feel like I'm being punished for my father's death. Not that I wished it—he was taken away by the Lord."

"What makes you feel you are being punished for it?"

"Whenever I go looking for a job, something tells me I must have done something wrong, because why should everybody refuse me? Maybe for that reason I have no luck."

"For what reason?"

"*I feel I did something bad.* I have no proof that I did it, but trouble makes me say it."

"What did you do that was bad?"

"I was selfish."

"How?"

"If my father told me to do something and I said no, I thought by not obeying him I would get revenge."

"Revenge in what sense?"

"You do to him what he does to you. I was eight years old then and I didn't know how good he was to me."

The patient recalled that as a boy he used to say to himself, "I wish I would never see him again."

"I was a foolish kid. I didn't want to be near him. Maybe I'm getting punished for it right now."

"Who would punish you?"

"Most likely the Holy One in Heaven. The Bible says you get punished if you don't honor your father."

Isaac's guilt feelings began to appear very soon after his father's death. At no time did he fancy himself in any way responsible for the death.

On the surface Isaac was devoted to his father, yet after the latter's death he developed a terrific sense of guilt. He recalled petty disobediences and particularly a wish he had had that he would never see his father again. So great was his feeling of guilt that "I feel like I'm being punished for my father's death". Considering that Isaac was so dependent on his mother, it seems justifiable to conclude that unconsciously—and perhaps at times consciously—he resented his father's existence, and that his father's death gratified a secret wish, thereby arousing a sense of guilt.

It is, of course, not implied that a feeling of guilt can *cause* schizophrenia. It does, however, seem possible that guilt, in coöperation with other factors, may lead to an aggravation of schizophrenic symptoms.

Case 7.—Louis G., born in 1913. A full report of this case, prepared in the spring of 1930, has appeared elsewhere.[1] The data important for the present discussion are the following:

The parents were not happy, the father being a colorless individual and the mother a comparatively young woman who had married him at the behest of her parents and had regretted it ever after. Louis was preceded by two boys. When he was nine months old, the mother returned to Russia, taking her three children with her. Her husband intended to join her, and they were planning to remain permanently in Europe, since it was so difficult to make a living in America. However, before the father joined the mother, the War intervened and the trip was postponed. Eventually conditions in Europe became so bad that the mother changed her plans, and in November, 1922, she and her children returned to America. Louis, then a boy of nine, saw his father virtually for the first time.

During the eight years in Europe, the mother and her children were exposed to many dangers and hardships. This led the mother to adopt an over-protective attitude toward Louis, partly because he was then her youngest child and partly, perhaps, because she sensed that unlike his brothers he was immature for his years. Louis' dependence on his mother was apparent, even long after their return to America.

The reunion of the father and his boys was not happy. He seemed to regard them as strangers. Indeed, when two children were subsequently born, he used to say to his wife, "These two are mine; the other three are yours."

In the summer of 1923—*i.e.*, about nine months after returning to America—Louis began to suffer from a chain of symptoms leading to the appearance, in May or June, 1927, of the following phenomena: He was from time to time aware of having certain "bad thoughts". Having had a "bad thought", the recollection of this thought a few minutes later would make him panicky; he feared that the thought would come true, and to prevent this he developed a certain ritual. Chief among the "bad thoughts" that so annoyed Louis was the thought that he would murder his father. Early in 1930 he began to show more definitely schizophrenic symptoms and had to be placed in a mental hospital in May, 1930. There he was well-behaved and quiet. He was discharged in October, 1930.

Data pertaining to the problem of guilt were revealed in two interviews. On April 18, 1930, Louis was telling me how his hatred of his father had reached an unusual pitch. His father had mistreated him and "certain bad thoughts about him flashed through my brain".

"What were they?"

[1] See "Archaic Regressive Phenomena as a Defense Mechanism in Schizophrenia," by M. Levin, M.D. *Archives of Neurology and Psychiatry*, Vol. 24, pp. 950–65, November, 1930.

"Certain thoughts like if you hate a person. And these thoughts made me worry. Certain thoughts that I didn't want—thoughts about hatred—*certain thoughts like I didn't want to get well.*"

In the remainder of the interview Louis revealed that the bad thoughts were that he would kill his father.

In an interview on October 30, 1930—the day after his discharge from the mental hospital—Louis said, "The main thing now is, I'm afraid of the devil." He had heard other patients at the hospital speak of the devil. "If anybody acts insane, it's the devil that makes them do it."

"What does this have to do with you?"

"If I go in the right way, I think the devil is going to kill me, because the devil is for wickedness and evil. I think he has a strong power. Many times I would get mad and say, 'To hell with the devil!' and then I would be afraid that maybe the devil would punish me for having said that. . . . If I would get well and act right, he would punish me. That's the reason I'm not well. *Fear of the devil prevents me from getting well.*"

"How many people go in the 'right way'?"

"The majority."

"Why doesn't the devil punish them?"

"Because God is stronger than the devil."

"If God protects the majority, why will He not protect you, too?"

"I'm a different case."

"In what way?"

"The ideas that I have. I fear the devil, and therefore I'm not worthy to be protected."

"How do you know God does not protect those who are different? Doesn't He protect the blind?"

"I'm different, because I'm more evil. If you're blind, it doesn't mean anything—your thinking can be normal—you just can't use one organ; otherwise you are the same like other people. But I—I didn't go in the right way. It is true I done good things—I went to the synagogue—but I done bad things, too. If I feared the devil, that's a bad thing. A good person is not supposed to fear the devil. He is supposed to fear God and no one else. I used to think that if I went in the right way, the devil would punish me, and if I went in the wrong way, God would punish me."

Louis is an immature young man, dependent on his mother through the circumstances of his early life, who saw his father at the age of nine, practically for the first time. Shortly thereafter he reacted with symptoms which later proved to be a defense against a desire to murder his father. On April 18, 1930, he described an occasion on which his hatred of his father had reached a climax. On this occasion his hatred was so extreme that he entertained "certain thoughts like I didn't want to get well". We see here that, from the patient's point of view, hatred of the father was equated with being mentally sick. He could indulge his hatred, but only at the expense of sacrificing his desire to get well;

illness, in other words, was the penalty of his hatred. The interview of October 30, 1930, was even more revealing. Louis emphasized the fact that he had not "gone in the right way" —*i.e.*, (if we may read between the lines) contrary to folk ethics, he had entertained thoughts of murderous hatred for his father. In thus renouncing the path of rectitude, he had acknowledged his allegiance to "the devil". He was, therefore, wicked, different from other people, unworthy of "protection". His illness was a punishment for this wickedness: "Fear of the devil prevents me from getting well"; in other words, "My wickedness in hating my father is what causes me to be sick." So acutely was he in need of punishment that he could not tolerate the thought of going unpunished—*i.e.*, being well. Therefore, "if I would get well . . . he [a fictitious, but, to him, real devil] would punish me".

Here again, as in the case of Isaac, we cannot say that guilt caused the schizophrenia. It does, however, seem to have been an important factor in the chain of developments which began nine months after the patient was thrown with his father.

Case 8.—A young man of twenty-one was examined at the Willowcrest Convalescent Home in August, 1929. He suffered from anxiety attacks which had begun one year previously, in September, 1928.

The patient related how for some unknown reason he had, in February, 1926, conceived the idea of wearing heel pads in his shoes. He wore these pads regularly until August, 1928, when, again for an unknown reason, he discontinued the practice. One week later a physician, while administering ultra-violet light, called attention to a slight twitching of the muscles anterior to the head of the fibula in one leg. The patient for the first time scrutinized carefully his knees and noticed that the heads of his fibulæ were, as he thought, unduly prominent. He was deeply chagrined at the thought that he might have brought about what he deemed a deformity by his senseless wearing of the heel pads. This thought annoyed him even as late as the date of my examination, in August, 1929. He said, "I'd hate to think I produced it myself by wearing those heel pads. I wouldn't like to have my legs distorted like that. It would spoil my physical beauty. I'd like to have legs that are well formed. I've always had nice girl's legs."

The patient was a rather effeminate-looking young man, with feminine hair distribution. He had on many occasions played the part of a female impersonator in theatrical performances and derived satisfaction from his skill at such impersonation. However, a few days prior to my examination, he had staged a female impersonation at an impromptu performance of guests of the convalescent home, and some girls sitting in the front row had twitted him, remarking that from the knotty appearance of his legs, it was easy to see that he was a boy and not a girl. His reaction to this is interesting indeed:

"As soon as the girls said that, the thought came into my mind that I must have spoilt my legs with those heel pads—and the thought didn't please me! I guess if I hadn't used those heel pads, I'd have smoother legs. I guess it sounds funny for a member of the male sex to say that—it must sound like a fairy." The patient had had frequent heterosexual, but no homosexual, experiences.

In taking sun baths, he was always careful to see that the lateral surfaces of his knees were well exposed, hoping that in this way his knees would fill out and his fibulæ become less prominent.

Considering the strong evidence of a homosexual constitution, it seems not improbable that the wearing of the heel pads was motivated by an "unconscious desire" to be feminine and to wear the equivalent of high-heeled shoes.

The anxiety attacks began in September, 1928—a few weeks after the discovery of the prominence of the fibulæ.

The patient recited this story not without hesitation. He had never before confided it to a living soul. At the end of the recital, he breathed a sigh of relief, saying, "I feel as though there is a burden off my chest. I feel clear—*as though I'd done something wrong and confessed it.*"

The patient had certain homosexual complexes and was upset by the discovery of a fibular prominence which rendered imperfect the girlish contour of his legs. Recognizing the personal nature of these complexes, the patient had kept them to himself. When he finally discussed them in a psychiatric interview, he felt "as though I'd done something wrong and confessed it". Evidently the complexes were attended not alone by a certain degree of shame, but also by a sense of guilt.

Jones[1] calls attention to the fact that in every case of morbid anxiety it is possible to find evidence of guilt. He cites Shakespeare's "Thus conscience doth make cowards of us all". It is, therefore, noteworthy that in the present case one finds a feeling of guilt in close association with a topic that was in turn related to the onset of anxiety.

Case 9.—Rose S., born in 1900, married in 1917. She had three children, born in 1921, 1923, and 1927, respectively. In March, 1924, when her second child was eight months old, the patient began to suffer from severe occipital headaches and "dizzy spells", which formed her present complaint. Careful neurologic studies at different times revealed no evidence of an organic basis for her complaints.

Interviews with the patient in 1929 revealed an unusually intelligent, unhappy young woman. She stated that she had been in perfect health until one day in March, 1924, a moment after she had placed her eight-months-old baby in the tub. "I put my child in the bath tub and all of a sudden I got numb all over and got a dizzy fainting feeling." She was able to go to the wall and by knocking attract the attention of the

[1] "Fear, Guilt, and Hate," by E. Jones, M.D. *International Journal of Psycho-Analysis*, Vol. 10, pp. 383–97, October, 1929.

neighbor in the next apartment. She then returned to the tub, took the infant out, and put it to bed, after which she lay down on the adjoining bed. Then she lost consciousness, although when questioned further, she was not certain whether she had actually lost consciousness completely. She could remember only that her eyes had been shut and that she had heard loud noises in her head, and "the next thing I knew was that I opened my eyes and saw a doctor there".

In many interviews the patient insisted that in spite of all negative studies her symptoms were of organic origin. She strenuously denied the possibility of emotional factors. At the same time, she intimated that she had had a most bitter disappointment in her married life. After a great deal of hesitation she revealed that her happiness had been ruined early in 1924 by the discovery that her husband was a confirmed gambler. He had been a skilled craftsman, earning $60 and more a week. They had put something aside every week, and when her second child was born, in July, 1923, she was secure in the belief that they had over five thousand dollars in the bank. She was at that time perfectly happy. It therefore came to her as a violent shock to learn a few months later that they in fact had nothing, that her husband had in the course of years gambled away every penny. Every shred of happiness she had ever enjoyed was torn away. On three subsequent occasions her husband accumulated some savings and promised to reform, but each time he succumbed to his vice.

The onset of the symptoms, in March, 1924, occurred a few months *after* the discovery of the husband's gambling.

The occurrence of the patient's first symptoms, while bathing her infant a few months after the sudden wiping out of her happiness, gave rise to the suspicion that the symptoms were a reaction to a conscious or unconscious desire to drown the child, the innocent symbol of her marital unhappiness. A number of observations lent support to this theory.

In the first place, the patient was extremely sensitive about the topic of hatred for one's children.

1. Thus, one day she was permitted to be alone with her chart in the out-patient clinic of a hospital where she was being studied from the organic point of view. Reading her chart, she was horrified to find a detailed report sent to the hospital by a social worker. Later, during one of my interviews with her, she referred to this incident, deploring that the intimate facts of her life had been spread on a hospital record without her knowledge or consent. Significantly, of all the intimate data included in the report, the patient mentioned only one point that had aroused her resentment: the report had intimated that to her her children were not all alike. "It actually said that I like the youngest child best and that the older child has a temper! Well—what of it? All children are the same to a mother. A mother can't help it if she hugs the younger child more. She can't always be hugging a big boy of nine." The patient's sensitiveness over this intimation was impressive indeed.

2. After the patient had indicated to me that there was a deep hurt in her life (her husband's gambling), she was for a time unwilling to reveal the nature of this secret. On one occasion she said, jestingly: "I hate to keep you puzzled. You might think I am another Gladys Parks. I assure you I am not." Gladys Parks, then notorious in the newspaper headlines, was the foster mother of two little children who had been murdered under circumstances pointing to her as the slayer. Consider-

ing the other circumstances of the case, we may be permitted to attach value to the seemingly trivial jest; in other words, a certain truth was concealed in the patient's remark that she might be taken for another Gladys Parks.

In the second place, the patient showed evidence of a feeling of guilt and of a corresponding desire for self-punishment.

1. In November, 1929, when I suggested to her that she confide the secret cause of her unhappiness, she replied that she had never told it to a soul and would never want to tell it. She then made the remarkable statement that she would not want to tell it *even if she knew that the telling of it would make her well.*

2. In October, 1929, she made the statement that in spite of her symptoms—which were so severe that she often contemplated suicide—she was much happier than she had been prior to the onset, when she had health and money. Such a statement is clearly indicative of the existence of strong guilt feelings, which, paradoxically, permit the patient to be "happy" only when she is being adequately punished.

3. After finally telling me of her husband's gambling, the patient related that ever since the onset of her neurosis, she had had frequent dreams *in which he is gambling.*

This case is open to the following interpretation: The patient was happily married until one day she learned that her husband was a gambler and that he had lost all their savings. Foreseeing that her life was destined to be unhappy, she must have thought that her marriage had been a tragic mistake, that it would have been better had her children never been born, that even now it might be better for them if they died or if she killed them. The thought of child murder aroused a feeling of guilt. The forbidden wish presented itself with unusual force one day as she placed her infant in the bath tub—a painful temptation indeed. Immediately her neurotic symptoms appeared for the first time. The neurosis, though it often made her wish for death, assuaged her feeling of guilt, which accounts for her statement that she was happier *after* the onset than before. The patient was extremely sensitive over the topic of child hatred, which is consistent with the assumption that repressed hatred for her children led to a feeling of guilt and to her neurosis.

In a case in which an event at the age of twenty-four leads to a feeling of guilt, it is worth asking whether there was not an earlier guilt-provoking situation which was "activated" by the later event. In the present case there are no data pertaining to this point.

The recurrent dream in which the husband is gambling is noteworthy indeed. The first occurrence of this dream was after the onset of the neurosis. Since her husband's gambling

was the cause of her unhappiness, we might see in this dream a fulfillment of the wish for punishment. An additional explanation suggests itself. Freud[1] has called attention to the fact that in patients suffering from traumatic neurosis, the dream life "continually takes the patient back to the situation of his disaster, from which he awakens in renewed terror". Freud deems it characteristic of traumatic neurosis that the trauma occurs at a moment when the patient is completely off his guard—*i.e.*, free from apprehension, apprehension to Freud meaning the state of mind of a person who is aware of danger and able to plan for it. The lack of apprehension is a necessary condition for the development of a traumatic neurosis. In Freud's opinion the recurrent dreams of the trauma "are attempts at restoring control of the stimuli by developing apprehension, the pretermission of which caused the traumatic neurosis". There is an impressive resemblance between the present patient's neurosis and traumatic neurosis, and it is possible that Freud's explanation may apply also to the recurrent dream which she reported.

DISCUSSION

In the following discussion we shall exclude Case 1, in which manifest guilt was of a trivial nature. Of the remaining eight cases, five (cases 2, 3, 4, 5, and 7) showed obvious evidence of antagonism toward the parent of the same sex. In Case 6, the patient outwardly showed great respect for his father. Inwardly, however, he harbored a secret antagonism, which made him feel guilty, as a result of which later in life he reproached himself severely for having occasionally disobeyed his father in trivial matters. In cases 8 and 9, the evidence found on cursory examination did not indicate any antagonism toward the parent.

Mere figures, however, fail to convey adequately the importance of antagonism toward the parent as a determiner of guilt. This importance is best understood from a study of the cases. Thus, in Case 5, the neurosis began a few hours after a scene in which, forced to choose between obeying her mother and obeying her own wishes, the patient chose the latter. In Case 7, in which an impulse to murder the father

[1] See his *Beyond the Pleasure Principle*, translated by C. J. M. Hubback. London: International Psycho-Analytical Press, 1922.

was the principal topic of concern, the patient was acutely conscious of the fact that he was sick because of "fear of the devil"; *i.e.*, because "I didn't go in the right way".

It is noteworthy that although the cases are few, the actual manifestations of guilt were quite varied.

1. In cases 6 and 7, both of them schizophrenics, there was a well-marked conscious feeling of guilt, with a strong tendency to self-reproach. Louis (Case 7), in particular, was conscious of having "gone in the wrong way," of having "feared the devil, instead of God".

2. In cases 4 and 6, the patient felt obliged to assume the blame for events of which he or she was really innocent. This was particularly apparent in Case 4, in which the patient felt somehow responsible for errors made by other workers in the office. In this case the feeling was an obsessive one—*i.e.*, the patient realized well enough that in reality she was free of any responsibility for the errors. On the other hand, Isaac (Case 6) seemed really to believe that his inability to find a job (times were very bad and jobs scarce) was a punishment.

3. In Case 8 there was a feeling of guilt, incomprehensible to the patient, connected with certain homosexual complexes.

4. In cases 5 and 9, no conscious sense of guilt was revealed. In each of these cases a neurosis appeared, circumstantial evidence pointing strongly to a sense of guilt as one of the causative factors. In Case 9 the desire for punishment via neurosis was striking. Though her neurosis made her uncomfortable to the point of contemplating suicide, the patient said that she was "happier" than she had been prior to the onset. At one time she said that she would maintain her secret even if she had a way of knowing that revealing it would make her well.

5. Punishment dreams were found in cases 3 and 9, and a punishment phantasy in Case 2.

SUMMARY

These nine cases seen in the Psychiatric Department of the Community Health Center illustrate the importance of guilt—and the attendant desire for self-punishment—as a determiner of conduct and thought. The influence of guilt is shown in the formation of neurotic symptoms, in the desire to take unmerited blame, and in the occurrence of punishment dreams and phantasies.

SOME MENTAL-HYGIENE ASPECTS OF COMMUNITY PROCESS

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IT should be stated at the outset that what follows in this essay represents the reflections, not of a psychoanalyst, a psychiatrist, or even a psychologist; my occupation, if it must be labeled, might be called that of social analyst. But I have discovered that social analysis cannot go far without recognizing that many of the most important human interrelationships are colored and conditioned by factors that belong to the category of mental hygiene. Indeed, it seems to me that the most significant of all conditionings (in the sense of Pavlov's law) in human behavior are socially derived before they become physiologically canalized. But my present concern reverses the formula—I am preoccupied with the manner in which so-called mental irregularities condition, influence, and qualify the social process. (By analogy, this might be thought of as the circular-reflex aspect of social process.)

My thesis restated, then, is this: Mental hygiene and the sociological disciplines intersect, or are related to each other, at those points where the quality of the social process is primarily conditioned by "abnormal" behavior on the part of functional participants.[1] This relation between the two sets of disciplines is now vaguely perceived, but it is my belief that it will become extremely meaningful in the near future. In fact, the time is rapidly approaching, it seems to me, when necessity itself will cause the devotees of these varied disciplines dealing with human conduct to give collaborative attention to each other. The over-specialized approach has already distorted the picture and has led to attachments that are not merely unscientific, but that produce pseudo-scientific assurances.

[1] The term "abnormal" is, of course, question-begging; perhaps "irregular" would be preferable. But the language difficulty involved in all of the social and psychological disciplines (they cannot, I believe, be called sciences) is too great to submit to clarification by an individual author.

This hoped-for *rapprochement* between specialized human disciplines, which may in the end permit specialists to work together and not at cross-purposes, must begin with a candid confronting of differences. Psychoanalysts, for example, have appeared to assume that they could deal with the maladjustments of discreet individuals, as related to other individuals and to an objective environment; they have further assumed that "normal" social relationships might be established when these internal and individual maladjustments were somehow "straightened out".[1] The underlying assumption of this postulate of the psychoanalysts reduces finally to this: the environment in which human behavior takes place is objective, knowable, and relatively free from confusions. Those devoted to social studies, on the contrary, begin by assuming that the environment—and particularly that aspect of the environment which may be called social—is not obvious, readily knowable, or simple; to know and to understand it is, indeed, the major technical task of social analysts.[2] He assumes further that most of those attributes (traits) which are commonly referred to as "human" are either directly or indirectly derived from those conditioned mechanisms of behavior which result from the interaction of personality upon personality, or organism upon organism. Communication, for example, the means by which individuals are increasingly related to each other, is a socio-physiological phenomenon.[3] The social analyst, moreover, cannot assume that a "normal" society exists and that individual adjustment to its norms constitutes mental health. On the contrary, he tends to view the social problem, not as a juxtaposition between individual and society, but rather as an interweaving unity of individual and social reality. "Diseased" individuals do not participate in a "healthy" society; in so far as there are mentally diseased individuals, they *are* the society in which they participate. Consequently, whether society is "sick" or "well" depends upon who does the observing.

[1] See *Public Opinion*, by Walter Lippmann. New York: The Macmillan Company, 1927. pp. 27–28.

[2] It should be mentioned that Freud appears to recognize the complexity of the social environment in his later writings.

[3] See Chapter V in *Experience and Nature*, by John Dewey. New York: W. W. Norton and Company, 1929.

The above is but one of the elementary discriminations that needs to be made before psychiatrists and social analysts can collaborate fruitfully.[1] But this undertaking is not our present task. I should prefer at the present moment to display certain social situations as observed in local communities, situations that seem to me to involve a distinctly mental-hygiene factor as the principal conditioner of the social process. A considerable literature already exists with respect to such social behavior as is characteristic of individuals in crowds or mobs.[2] Here the irregular element is clearly observable, since individuals behaving as units in mobs or crowds engage in dispersed responses (activities) that are wholly or partially a-typical—that is, observably unlike the activities with which their personalities have become associated. Our present search is, however, for illustrations on the level of more common or ordinary experience, and particularly that area of experience which connects individuals with their local community processes. I, therefore, proceed to furnish such illustrations, stated in briefest form and accompanied by a minimum of interpretation.

Situation Number 1.—In an extremely backward rural community of the Middle West, there exists a particularly stubborn resistance to change in agricultural practices and methods, a resistance that is not common to the surrounding communities. A recurrent phrase used by the residents of this community whenever confronted with a proposal emanating from the "outside" gave the clue to this community mind set. The natives met each approach, whether of the commercial agent or the representative of the agricultural college, with a suspicious response accompanied by the term "Bohemian oats". Investigation revealed that this phrase originated more than a half century before, when an unscrupulous salesman had sold what he pictured as a superior brand of oat seed to the fathers and grandfathers of the present generation. The agent named his seed "Bohemian

[1] *The Social Basis of Consciousness*, by Trigant Burrow (New York: Harcourt, Brace and Company, 1927), is an excellent introduction to this discriminating procedure.

[2] See LeBon, Tarde, Ross, Martin, and others. Also, see vivid description of such behavior in *Americans*, by Salvador de Madariaga. Oxford: Oxford University Press, 1930. p. 36.

oats'' and upon the basis of the claims that he put forth, agreed to buy five bushels of seed from each farmer at harvest time for each bushel sold to the farmer. The whole transaction was a fraud and the salesman was later apprehended and sent to prison. But ''Bohemian oats'' became a tradition in this community that endured for three generations and so far conditioned the behavior of its residents as to cause a distinct differentiation between it and its neighboring communities.

Comment.—The abnormal feature of this situation lies in the fact that an attitude of suspicion toward the outsider—which is, of course, normal enough for pioneer communities—was perpetuated as a tradition and ultimately became a folk myth. Consequently, it not only conditioned the conduct of residents, but actually shut them out from evolving experiences. *Community* mind sets of this sort furnish the basis for gradients of community development. They begin as rational reactions to disappointing experiences and culminate as irrational fixations toward whole areas of possible experience.

Situation Number 2.—In a suburban community near New York, there lived a man who gave signs of unusual thirst for power. He took a leading part in all important activities, maneuvered himself into positions of authority, and played a dictatorial rôle wherever possible. In a very short period, covering ten years, he became the leading force in the chamber of commerce, the town council, the school board, a church, and the local branch of the dominant political party. His claims to leadership were based upon two presumptions: namely, (a) that, being an engineer, he understood the principles according to which community affairs should be managed; and (b) that, being a man of affairs in the metropolis, he possessed the capacity to add prestige to the suburban community in which he lived. Investigation revealed that this man was not an engineer, but held an inferior position in an engineering office, that his prestige among his fellow workers was at a very low ebb, and that on the whole his rôle in his occupational surroundings was that of a submissive and inferior person. This discovery quickly led to a deflation of his leadership, but it also precipitated an attitude of sus-

picion within the community which now operates as a barrier to the exercise of valid leadership.

Comment.—The above situation reveals what may happen when, under the conditions of two focal areas of existence—namely, the anonymous metropolis and the intimate suburb—a person may use one sphere of experience as a compensation for the deficiencies of the other. As urbanization tends to fractionalize life and experience, it often happens that one part or fraction of personality comes to be an antithetical compensation for another. In the above instance, over-compensation for lack of security in one locale led to a disruption of community processes in another.

Situation Number 3.—In a community somewhat outside the usual commuting area of a metropolitan center—a district of great natural charm, but retaining its distinctly rural cultural flavor—a small number of city families gradually came to reside. Being more progressive in their attitude toward the problems of education, these newer residents soon began agitations intended to improve the local school. On account of the usual lethargy regarding public affairs, these progressive persons were soon able to elect members to the school board who were favorably inclined toward change and improvement. When decisive power was attained, they began a movement to discharge the school principal. At this point the community divided sharply into two groups—those who stood firmly on the side of the principal and those who desired his dismissal. The newer residents gained the support of a number of indigenous families, but examination showed that these were for the most part persons dependent in some manner, principally economic, upon the new group—they were, that is, real-estate agents, shop-keepers, and so forth, persons who foresaw the economic advantages of increasing the number of prospective consumers in the community. But the older residents soon marshaled their forces and by subterranean methods of control organized an opposition that completely manipulated the next-ensuing school election. As a consequence, the new residents banded together upon the basis of their common defeat and decided to finance an independent and private school of their own. The two groups now evolve independently as "social islands" in the community, develop-

ing additional class consciousness, suspicion, and enmity; every issue that comes before the community is rationalized, not in terms of its intrinsic merits, but rather in terms of the conflict between these two insulated groups.

Comment.—In situations of this type, the underlying cause of abnormal community process emanates from group security or insecurity. Rational considerations of public questions soon fall to the irrational, emotional level when the security of one group or another is seriously threatened. In the above case, for example, the conflict was not in reality waged over the school principal or over school improvement, but over the fact of group control. In the end, reconciliation became impossible and continuing disintegration of the democratic community process became a necessary consequence.

Situation Number 4.—The dualistic character of community development is illustrated by City X, which began its career as a railway center more than a half century ago. During the "boom" period, it appeared that this community might become a very important manufacturing city; its location was favorable and all that was needed was the attraction of capital and enterprisers, together with an essential supply of labor. But the community did not develop according to schedule and still remains a small city with the railway shops as the main industry; even this source of economic activity and security has decreased in importance since more and more of the shop work is being transferred to larger establishments elsewhere on the "line". But during the more promising period, services of various sorts originated and still persist to a degree not warranted by the size and resources of the population. For example, there are two taxicab concerns, two coal dealers, two banks, two meat markets, two general stores, and so forth. Since there is scarcely enough business to make both establishments in each field really profitable, all of these dualistic concerns operate on a marginal basis. The psychological effect of this marginalism is to place the blame upon rivals, and this has actually happened and to such an extent that the community now consists of two sets of warring camps, each coterie giving allegiance to one or the other of the competing concerns. Pathological evidences of this dualism break out with suddenness and violence from time

to time, beginning with physical encounters and continuing as court litigation.

Comment.—The abnormal aspects of this situation flow from the facts of unreasoned community planning. It is obvious to the outside observer that the community would be better off with fewer services more efficiently managed. But those who took the risks of establishing businesses in the "boom" days are no longer capable of viewing the situation in terms of community engineering; they place all relevant events within the context of personal rivalry—which immediately distorts each situation arising within the community. Moreover, steps toward community planning, such as might follow from the organization of a chamber of commerce, are prevented by the fact that the rival representatives cannot depersonalize their situation sufficiently to join in a common and coöperative undertaking.

Situation Number 5.—In a one-factory town the president of the corporation and his wife, being public-spirited persons, have supplied both the initiative and the resources for practically all community projects. They were instrumental in building a park and a recreation center, and in securing the services of the Y.M.C.A., the Y.W.C.A., the Red Cross, a dental clinic, and so forth. Whenever anything new happens in this community, its origins may be traced directly to this industry and to the president or his wife. In recent years, however, this industry has suffered reverses; the president and his wife spend diminishing portions of each year in the community and increasing portions in travel. Some of the social and recreational services that they initiated have already disappeared and others are sustained with difficulty. It now becomes necessary to appeal to the citizens for support, but such support is invariably lacking. Indeed, the residents now reveal attitudes of hostility toward their former benefactors, and the community as a whole sinks to lower and lower levels of responsibility and activity.

Comment: As in most instances of *paternalism*, this community illustrates how a normal community process may become abnormal when those with superior resources assume too much responsibility. Such persons invariably prevent the community from developing its own resources and thus, in the end, undermine its capacities. The fact that persons

thus demoralized should come to feel contempt for their former benefactors is thus easily understood as a part of abnormal human relations. Over-solicitude extended to communities may have the same consequences as those visited upon the child by his over-protective mother.

Situation Number 6.—A New England community has been attempting for the past three years to carry out the mandate of the voters who decided favorably upon a bond issue intended to furnish resources for the building of a garbage-disposal plant. Municipal politics is still conducted on the basis of the two-party system, and on this account each project of the party in power becomes at once the object of criticism for the minority group. In this case, the minority party, which had fought the bond issue and had suffered defeat, changed its tactics after the election; they then began to attack, not the garbage-disposal project itself, but its probable location. Engineers had selected a site that bordered upon the industrial section of the community, which was also the area of residence for the working-class population. Minority-party leaders fomented trouble among the working-class citizens by intimating that the wealthier residents were placing the garbage-disposal plant where it could not possibly be of annoyance to them, but where it would be particularly disagreeable for the workers and their families. A so-called citizens' committee was organized for protest purposes, and proceeded to utilize the courts in injunction action, and hostilities thereafter increased. Finally, the party in power requested engineers to find a new location for the garbage-disposal plant, but since no location could be found that would not be in the proximity of some group of residents, the same sequence of opposition followed. So far as I am aware, this community is still without its garbage-disposal plant, but it has acquired a set of class confusions and conflicts that are likely to disturb its social processes for a long time to come.

Comment: In this instance the real nature of the community project and its probable economies was relegated to the background the moment the issue was made to hinge upon class privilege. Irrationality took the place of an engineering approach, with the result that the question could not again be placed upon a reasonable level.

From one point of view it might seem advisable to leave the above situations without further comment, in the hope that they might furnish the basis for ongoing discussions. But a professor cannot be expected to remain strictly true to his pedagogical principles, and I am tempted to add a few leading queries and a bit of contextual reference.

1. If unadjusted individuals function within contexts of circular social response, is it not advisable and in the interest of clarity to abandon the terms "normal" and "abnormal" or, at most, to reserve their application for those individuals who drop below the functional level?
2. Do any items in the above situations lead to the implication that isolation and treatment of individuals is not capable of restoring or creating a "healthy" social process?
3. If social diagnosis is called for, does this imply that social therapeutics must necessarily follow?
4. Should the concept of "cures" be eliminated?
5. If the disciplines of mental hygiene and social analysis were to collaborate on any of the above situations, what might be considered a valid division of labor?
6. Is it valid to assume that the discipline of mental hygiene might be utilized for purposes of comprehending the origin and development of "blocked" social situations, whereas the social disciplines might use their analytical instruments primarily for the purpose of setting up "reconditioning" demonstrations and experiments?
7. At what points might the facts or "insights" of mental hygiene contribute to a more meaningful conception of social analysis, and *vice versa?*

Queries of this sort might be proposed *ad infinitum,* but enough has been suggested to indicate where some of the perplexing problems lie. Further progress depends largely upon exchanges between persons who recognize the significance of the general problem and possess appropriate backgrounds of experience.

The comprehensive contexts within which the above problem may be said to lie are: (a) the development of the sciences, and (b) social progress. Scientific advance involves, apparently, a dual procedure; division and subdivision is a

necessary process, but at certain points this specializing trend appears to confuse rather than to illumine knowledge; consequently, fusions and re-combinations of various sciences are needed in order to restore perspectives and to furnish clues for fresh investigations. It is my conviction that all of those disciplines (which tend to become sciences) dealing with so-called abnormal behavior have specialized either prematurely or at a too rapid rate. Professional aspirations have, in some cases, outrun scientific criteria and the result has been emotional and professional isolation where the problems involved clearly called for collaboration and joint experimenting.

That haunting problem of the One and the Many which has no persistently confused the course of civilization in America appears to present itself to each age under different guises. At present we all tend to shrink from the impending standardization of a so-called "machine civilization". We cannot make up our minds with regard to the kind of society that is really desirable and this confusion reënforces our fears. The disciplines concerned with the nature of human conduct are expected to help us find our way. Ancient social structures have become pliable and gigantic experiments are imminent and in process. Both science and philosophy (fact and value) will be needed for our guidance, and those to whom this essay is addressed will want new perspectives. It may not be amiss, therefore, if my readers are reminded that one of our greatest of thinkers, Ralph Waldo Emerson, appeared to foresee our present dilemma with clarity at the very beginnings of the "machine age", and also that a friendly visitor, Thomas Huxley, warned us pointedly nearly a half century ago. The main difficulty in modern culture derives from the fact that social masses tend to become all-powerful, while the individual personality sinks to lower levels of effectiveness. And effectiveness—or, in Emerson's words, self-reliance—is the basic desideratum of sanity. This, then, is the context of social progress within which our general problem needs to be located.

PUBLIC-HEALTH SERVICE AND MENTAL HYGIENE IN THE U. S. S. R.*

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MY purpose here is to tell of the tendencies in Soviet public-health work that have become the basis of the mental-hygiene movement in the U.S.S.R. As everywhere else, mental hygiene in the U.S.S.R. originated in psychiatry and now has changed the aspect of psychiatry itself. Soviet public-health work has been built up as a tremendous cultural and economic force under the single leadership of the People's Commissariats of Public Health, which have been able to unite all the most important scientific and social activities under their banner. The social character of Soviet public-health work is shown in the fact that connected with practically every one of the Soviet institutions for medical and prophylactic work are special organizations of working men and women and peasants, whose wide participation in public-health work constitutes them a staff of social workers hundreds of thousands strong.

Soviet public-health work is essentially preventive in character. It has, therefore, built up a very widespread system of institutions for the protection of motherhood, childhood, adolescence, and so forth. Special stress on the health protection of large masses of the population has brought to the fore, as its principal project, the fight against social diseases through a system of dispensaries, the success of which, under Soviet conditions, has given to the whole field of scientific medicine a clear understanding of the very important part played by social factors in etiology and therapy.

Soviet public-health work is closely connected with the educational problem, with the problem of building up a new,

* Address delivered before a meeting of The Russian-American Institute and the International Migration Service, June 19, 1930.

healthy life, and it extends far beyond the narrow limits of treating diseases and instituting general sanitary measures.

Even during the period of restoration of the economic condition of the country (from 1923 to 1925), Soviet public-health work not only gave its attention to the proper organization of preventive aid, but went beyond this by directing its efforts toward the reorganization of medicine itself, in order that it might work effectively in the field of disease prevention through improving the health conditions of labor in its working and domestic life.

The problem of overcoming professional diseases and those developed by communal and anti-hygienic habits has caused the Soviet public-health service to develop a new system of service to the population—that of dispensaries. By this method of service, we secure, first of all, a record of the mental and physical health of certain groups of the population, preventive aid to the population by special social-therapeutic institutions, and active participation in public-health work in the matter of changing conditions that cause disease. The dispensary work is combined with periodic mental and physical examinations of certain groups, with aid rendered according to a definite plan, and with the participation of the workers themselves in the protection of their own health.

At the present period of economic reconstruction, public-health work has taken on still more importance as an economic factor in the industrialization of the country, the rationalization of labor. It carries on a large special program of research and practical work in the way of studying labor in its new conditions, and now aims not only at preventing disease, but at increasing the sum total of health of the working masses by creating conditions under which the social, physical, and mental value of each and every working man and working woman may be brought to their maximum.

The development of a healthy generation, with the maximum growth of its physical and mental forces, the protection of motherhood and of the health of children from infancy, the dissemination of knowledge of medical culture, the practical application of professional vocational selection, the creation of healthy professional habits, the development of physical culture, and so forth, occupy the first place in the

field of public-health work. Making no distinction between the value of physical and of mental health, Soviet public-health work treats both as one closely allied problem, involving not only physical, but mental hygiene. From the very beginning, Soviet public-health organization has included the energetic development of the mental-hygiene movement.

The child-health program has led to the creation of a special organization to deal with preventive psychoneurology for children and pedology,[1] which developed out of mental hygiene. The very broad system of preventive dispensaries for children with psychoneurological sections is similar to that of the child-guidance clinics in this country. In 1928 there were in R.S.F.S.R. 124 such children's dispensaries. All of these organizations deal with child mental hygiene.

The penological code of the Soviet Government has as its aim not the punishment of the criminal, but his reëducation and the protection of society. Among the measures of the code are many of a medical character. The part that psychiatry has played in introducing such measures into courts and prisons is very great. The compulsory psychiatric examinations of criminals in courts and the development of a special mental-hygiene service for the prison population have made psychiatry a tremendous power for social therapy in the field of crime. Scientific institutions, laboratories in prisons, and special clinics for studying the personality of criminals have brought mental hygiene into a close relationship with criminology and penology.

In the fight against juvenile delinquency, the influence of psychiatry and mental hygiene is exerted through special "Commissions on Cases of Minors". There are no courts for minors in the U.S.S.R., in the proper meaning of the term. Instead of courts, we have these social-educational commissions which consist of psychiatrists, educators, and lawyers. (In Central Soviet Russia—R.S.F.S.R.—there are 300 such commissions.)

As a result of its preventive work, psychiatry has not

[1] "Pedology is concerned with the psychological and physical development of the child from birth to maturity. It studies the biology and psychology of human growth." Albert P. Pinkevitch, President of the Second State University of Moscow, in his book, *The New Education in the Soviet Republic*. New York: John Day Company, 1929.

confined itself to developing organizations for the care of the chronic insane, but has itself become definitely preventive in nature. That is why its main emphasis is placed upon neuropsychiatric or mental-hygiene clinics, sanitariums, preventoriums, etc. Such clinics not only find the diseased and treat them, but often do away with the necessity of placing such patients in psychiatric hospitals, leaving them in their homes instead. Preventive work among the healthy population is also carried on by these clinics. These dispensaries are allied with a number of institutions of a social-therapeutic nature, such as night sanitariums, dietetic restaurants, special stations for occupational therapy for out-patients, etc. Here the working people, without leaving their work, can receive the aid that is of benefit to their health. Through their social workers these dispensaries are able to influence the corresponding Soviet institutions with the aim of changing the conditions of labor and everyday life. Connected with the dispensaries are special workers' associations for mental hygiene.

The active part that mental hygiene is playing in the rationalization of labor has resulted in a special type of research and practical work in the field of mental public-health service. Physicians who specialize in mental hygiene make clinical studies of labor conditions and their influence on health. With such work being carried on, we can, not only grasp the pernicious influences of non-rational work even in its least manifestations, but scientifically study the dynamics of the development of diseases.

Mental labor is studied in the same way by means of special mental-hygiene departments for students of certain universities. Preventive dispensary work is carried on in Moscow among the working population of over 400,000 persons and all of its child population that can possibly be reached. For out-patient neuropsychiatric work Moscow has not less than 200 physicians who are specialists in this field.

The tremendous value of mental-hygiene education for the masses has brought about the establishment of open mental-hygiene consultations, which give the most varied advice on such matters as the prevention of nervousness, the fight against alcoholism, eugenics, the rationalization of labor, and

recreation. Besides its practical routine work in this field, the Soviet mental-hygiene program has the definite aim of synthesizing new practice with new theory, leaving the method of the metaphysical and moving toward the simple empyrical. Mental hygiene is a part of social hygiene and it must make psychiatry a matter of bio-social discipline. In the matter of this new trend in psychiatry, the Soviet psychiatrists and some of the psychiatrists of the United States are in common accord. In 1913, as a member of the International Congress of Physicians in London, I was present at a discussion between Adolf Meyer of Baltimore, Maryland, and the Scotch psychiatrists as to the best methods of developing psychiatry. History has shown the correctness of the view of Adolf Meyer and American psychiatry.

MENTAL HYGIENE AND PROGRESSIVE EDUCATION

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MODERN education prides itself on being progressive. Its voluminous literature, its countless research programs, its conventions, its extensions, all present an admirable spirit of industry, of healthy ambition to improve the entire fabric of organized educational practice. When the desire to advance manifests itself in the enterprise of central authorities, results are necessarily slow in appearing, since democratic education inevitably involves a large measure of internal inflexibility. Hence, with those less patient advocates of progress who find themselves hampered by official conservatism, there spring up the numerous worthy movements that style themselves "Progressive" or "New".

If we ask, however, in what the progress consists, we are confronted with a question of no mean order. "Advance" implies some standard on which our judgments are based. Is our fundamental philosophy becoming enriched? Are our practices more in harmony with educational values ideally conceived? Or do we measure progress in terms of mere extension of educational facilities, or, again, in terms of improved conditions in our schools—bigger and better buildings, more maps, different-colored chalks, and the like?

Aside from the difficult problem of what the essential criterion should be, it is interesting to note that we frequently fall into the habit of measuring progress by changes in the conditions of the educational process rather than in the process itself—often, indeed, by changes in relatively unimportant conditions; and in this tendency, psychology, through educational psychology, has exercised a great influence. The present paper will endeavor to point out how this influence has developed, and to indicate how certain modern psychological movements and mental-hygiene enterprises are at-

tempting to suggest complementary, and probably more basic, emphases.

Educational psychology has usually dealt with two main fields—"individual differences" and "learning". In the former, emphasis was placed upon the results of mental tests, especially in regard to quantitative interpretation of the concept "intelligence". The latter included a somewhat detailed examination of experimental studies, designed to unearth the nature of improvement and the factors that affect the learning process. Both accepted the superiority of objective methods, interpreting "objectivity" in a narrow statistical sense. Since questions concerning the functional counterpart of "intelligence" as measured, or of "learning" as depicted by "increased efficiency", led to controversy, the faith of the applied psychologist was pinned more and more firmly to the quantitative data obtained under standardized conditions. Observation was increasingly confined to so-called "objective" experimentation, and facts pertaining to one's inner experience were regarded as of doubtful value, since they were observable only with great difficulty. Finally, all psychological controversy was shelved, since its problems were ignored, by those extremists who accepted the banner of Behaviorism, while still, strangely enough, retaining the dignified name "psychologists".

In other words, the tendency has been to promote inquiry into facts or conditions with which the educationist must reckon. This, in itself, is undoubtedly a very worthy field of investigation. But in our enthusiasm for positive and immediate results, the functional, truly psychological side has suffered. Further, the weakness seems to be more than one of overlooking the importance of the more ultimate aspects of "intelligence" and "learning"; for we have become so engrossed with "conditions" that the "processes" have been identified with the conditions themselves.

Let us illustrate this in the two fields separately. When "intelligence" is conceived only from the standpoint of standardized test scores, it becomes a gross condition rather than a functional ability. The old argument—that since our teaching methods have frequently been suited to only 50 per cent of the pupils in heterogeneous classes, because of the wide

spread in ability, while for 25 per cent they have resulted in boredom, and for the lowest 25 per cent they have been merely mystifying, therefore we should adopt a more homogeneous classification of pupils—is really most dangerous. It advocates homogeneity as a condition conducive to a standardized method of presentation—a method that will suit all, as if "intelligence" were the only variable among children. Under the old system, where a wide range of intelligence characterized almost all classroom situations, the need for individual attention was obvious to every teacher. With the "mental age" disparity no longer available as a universal explanation of backwardness or lack of interest, it is easy, as in homogeneous groups, to fall into the habit of expecting all members of the class to be equally able to benefit by a standard teaching procedure. The more discerning students of individual differences looked for other variables. Special interests, peculiarities of attitude, special intellectual abilities and disabilities, were studied. But since, apart from general intelligence, mental variations seemed to depend most largely upon the environmental influences that had interacted with the children from the time of conception, external conditions took the center of the stage. With Behaviorism, indeed, even "intelligence" was regarded as a line of deviation dependent mostly on factors operative after birth; individual differences were the results largely of learning; and the rate and range of learning depended on the conditions, the stimuli. Hence the study of stimuli and responses—but not of mental functioning itself.

This brings us to similar considerations in the field of learning. In its anxiety to discover laws of learning, psychology has paid much attention to the conditions under which learning takes place. The behaviorist, for example, is interested in the factors that affect "conditioning"; his laws deal mainly with "frequency" and "recency"—conceived scientifically, objectively. Thorndike places additional emphasis on "effect"—"satisfaction" or "dissatisfaction". But this terminology must not be confused with a functional system of concepts. The satisfaction is not really conceived as "strengthening the bond" in any mysterious, retroactive, psychological sense—Koffka's critical comments to the con-

trary.[1] This is brought out very clearly in Thorndike's recent book,[2] where the effect of telling the subject when he is "right" in his responses is made the condition *par excellence* of efficient learning, the negative effect of informing him when he is wrong being only very secondary. But Thorndike himself appears to have realized only imperfectly the fundamental difference between his approach and certain others, for he would have us believe that his term "bond" is comparable with such a functional term as "relation" (as used by Spearman, for instance[3]). In reality, all of his concepts that are basic in describing the learning process are no more than conditions, objectively conceived; and the fact that he has added [4] a number of words which in other settings do bear functional import—such as "belonging", "identifiability", and the like—only increases the confusion unless this fundamental distinction is recognized. In fact, his system would be meaningless if interpreted functionally.

So, too, with the principles of economy in learning, discussions regarding whole and part memorizing, the value of recitation as contrasted with rereading, the length and distribution of practice periods, and the like. These are comparable with our educational researches into methods of presenting material, which rely almost entirely upon objective observation and tend to promote the tendency to generalize the results, so that standard procedures may be advocated. Surprisingly little has ever been done towards determining the psychological reasons for the supposed principles of economical memorizing—a point to which we shall return later; and when any attempt is made to apply the "principles" themselves, the individual child is lost sight of in the experimental group.

Significant, in this connection, is the reaction against such formal experimentation in education made explicit by the mental-hygienist. For him, the cardinal condition influencing

[1] *The Growth of the Mind*, by K. Koffka. London: Kegan Paul, Trench, Trubner, and Company, 1927.

[2] *Human Learning*, by E. L. Thorndike. New York: The Century Company, 1931.

[3] *The Nature of "Intelligence" and the Principles of Cognition*, by C. E. Spearman. New York: The Macmillan Company, 1923.

[4] *Op. cit.*

behavior, and therefore the fundamental factor in directing the learning process, is the social environment. Education is, for him, a process whereby the child's development is governed by personal attitudes—the attitudes of parents, classmates, teachers, toward the individual child's behavior. Instead of the real, impersonal, objective elements of the situation, which receive the major attention in controlled experiments of the laboratory type, the personal factors are stressed. These, again, are "conditions", rather than "processes". But they come nearer to a functional connotation than the others, since they are the attitudes of human beings to a human situation. At the same time, the "explanation" of the consequent learning is still made in terms other than those portraying the inner process itself, and the emphasis of the behaviorist is implicit in the methods that are limited to this aspect. The advantage, from an educationist's standpoint, is quite marked, however, since personal influences can never be stressed without maintaining the central feature of Rousseau's paidocentricism.

But again this is not enough. From the point of view of immediate results, it is undoubtedly a healthy emphasis, since it not only counteracts the standardization tendencies inherent in applying the scientific abstractions of the objectivist, but also insists upon a modification of the educational organon. Instead of suggesting "reclassification of pupils" as the royal road to educational efficiency, supplemented by more scientific methods of presenting an experimentally graded curriculum, it inclines toward a program of educational experiences of such a nature that, despite heterogeneity in the school group, each individual will be stimulated in a manner conducive to his own greatest development. Such an ideal is a worthy objective indeed. But what is involved in its realization?

Progressive education has not yet provided an answer to this question. No one can expect any single movement, however broad and however well-established, to do so. But one is justified in looking for at least a statement embodying the appreciation of the nature of the question, from those who advocate the progressive method as the probable means of educational emancipation. Descriptions of progressive ex-

periments we have in great numbers. Clear expositions of the underlying philosophy are comparatively rare. Still more appalling, however, is the lack of any attempt to investigate the psychological functions that must be basic to any system of education. "Environmental conditions" receive the attention of psychologists, since these are to some extent subject to our control. But surely the power of control would be enhanced by a more insightful appreciation of the "why" in learning, expressed in functional terms.

Environmentalists themselves all recognize this, of course. But since the most commonly used complement of "environment" is the mysterious "heredity", they have been so anxious to deal with practical possibilities, and discard the apparently unprofitable mysticism of the eugenist, that they frequently overlook the child as well as his ancestors, and pay attention only to his surroundings. They usually credit him with some inherent motives, together with an I.Q. But apart from that, he is subsumed forevermore under a series of behavior categories and an array of witting and unwitting personal influences. Occasional lapses from the rigidity or consistency of the descriptive terminology necessarily occur, as when the terms "witting" and "unwitting" are applied to the behavior of the subject (the parent, for example) or when the child's evacuation is classified as "involuntary". But we have become hardened to such inconsistencies through long exposure to behavioristic literature. It would appear that the desire for "objectivity" is again responsible for the emphasis on environment when considering research projects, while the success of the clinician depends on his insight into the functional aspects of a behavior situation. Could we not to advantage pay attention to the substantiation of these functional assumptions, without which the clinician can never proceed, and without which educational programs would depend entirely on a trial-and-error procedure?

In the field of psychology, increasing recognition of this point is manifesting itself in several movements. It has always been the corner-stone of clinical psychology, even though the case-study method is not very well adapted to a scientific evaluation of those functional hypotheses that permeate the clinician's approach. Something more reliable must sup-

plement the case-study method of verifying psychological systems, and in this regard, the behavior studies of the environmentalist are making a very sound contribution. So, too, the correlational techniques of Spearman, Kelley, and others are providing increased facilities for demonstrating functional factors in mental constitution, which, when interpreted by psychological hypotheses, offer additional guidance to further research and application, especially since the hypotheses themselves may be further verified by objective procedures. Similarly, the weight of the *Gestalt* psychologists has for some years been added to this revival of a psychological approach to problems of learning and behavior.

Because of this tendency experimental work in the fields of individual differences and of learning is beginning to take its place in the mental-hygiene movement, and therefore in the field of educational research—but with a new emphasis. Its applications in the schoolroom will be less likely to endanger the individuality of the pupils, since it will be a part of the broader, essentially personal program of the geneticist. It should aim at presenting the developmental picture "from within", as a basis for directing the *process* of education, the *conditions* being largely the concern of complementary environmental studies. In this way, efficiency will have a twofold aspect; to the question of external efficiency will be added that of internal "mental" economy. These will never be antagonistic or controversial, but will constitute experimentally derived systems of mutually illuminating principles. And to devise the research setting that will assist in the realization of this objective is the real task of progressive education.

THE VALUE OF PSYCHOLOGICAL TRAINING IN ORGANIC DISABILITY AND DISEASE

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SOUND mental and sound bodily hygiene depend on a balanced view of human nature. By thinking of the human being as a highly differentiated and more or less unified psycho-physical organism, we avoid the extreme denial of its duality or its unity. In order to avoid the one-sided heresies of mentalistic and materialistic science, it is necessary neither to over-simplify the idea of the self by denying the reality of either mind or body, nor to over-complicate the problem by thinking of mind and body as two quite different things that live separately side by side and somehow interact.

A balanced view of the soul-and-body problem will modify our theory of the factors in disease. We shall avoid the one extreme of seeing only the mental factors in disease, without falling into the other extreme of admitting only material causes of sickness. We shall admit that organic disorder may disturb or destroy the mental functions, and that mental disorder may disturb or destroy the bodily functions.

In the history of medicine, the pendulum has swung from one extreme to the other. At one period, medical men declared that disease was due to the will of God or the devil, to the malice of the witch or the wicked. At another time, doctors inclined to see only physical factors in sickness. First came the spiritualistic extreme when all disease was ascribed to the power of the will; then came a materialistic reaction, when naturalistic determinism denied the power of the will in disease; and now comes the Christian Scientists' excessive faith in the power of the believing will to be well.

Rank's recent psychological works[1] provide a useful key

[1] See his *Grundzüge einer Genetischen Psychologie,* his *Gestaltung und Ausdruck der Persönlichkeit,* his *Wahrheit und Wirklichkeit* and his *Seelenglaube und Psychologie.* Leipzig and Vienna: Franz Deuticke.

to the understanding of extreme and contradictory ideas about the mind and the body. Every one has an active will to take power to the self and also a passive will to give power to the object. The self-assertive will glories in responsibility and aims at being the sole creator of health and destiny. The self-denying will shuns responsibility and aims at being the helpless creature of the omnipotent forces of nature or Providence. In proportion to their strength, each of these two basic tendencies inhibits, denies, or represses the other. The strong-willed person is apt to be very spiritualistic, stressing the power of the will in disease, or very materialistic, stressing the physical factors. It is painful to limit the will by holding a complex theory and making a compromise.

In the case of Mrs. Mary Baker Eddy, we see the denial of the destructive will to be ill in herself and its consequent ascription to malicious and alien wills against which her will to be well had but little resistance. This denial of a share in the responsibility for organic disorder is as widespread as the almost universal belief in witchcraft, demonic possession, and the evil eye. Such expressions of helplessness deny the limited power of the will over accidents, sickness, and senile decay. When reason admits the lack of magical power over death and disease, the mind tends to deny all power over bodily health. Some ascribe all disease to divine or demonic activity; others use medical truths about germs, toxins, glands, and hereditary trends as an alibi. But the sufferers who ascribe their sickness to spirits generally admit that their pain is a punishment for sinful self-will. And in so far as they have consciously or unconsciously broken the laws of psychophysical health, their admission is significant.

The classification of disease as either psychogenic or organic was an attempt to avoid the extreme beliefs. The will was admitted to be at work in diseases of the functional type, while in the production, intensification, and prolongation of structural lesions even a limited power of the will was denied. This theory was a sort of armed truce between the protagonists of fate and freedom, a compromise by division of territory. Some morbid states, such as hysteria and psychasthenia, were surrendered to the mentalists: others, such as tuberculosis and ulcer, were given entirely to the materialists.

The theory of purely mental and purely organic diseases is too neat and simple to fit the well-known facts. Freud saw that even in the so-called psychogenic disorder some constitutional factor is present. The psychoneurotic, destructive will may use any organ or function that is weakened by heredity or environment. Likewise there is a growing accumulation of evidence that the mind is a factor in organic disease, and the will to be well an indispensable condition of a permanent cure.

As an example, we may cite a case related by a pioneer in this field, Dr. G. Groddeck, in a paper read before the British Psychological Society in 1928. In 1901 an elderly lady came to see him about occasional abdominal cramp and continual pain in the back from renal calculus. Between 1901 and 1913, when she was given only physical treatment, she passed well over one hundred stones. After that period he began to combine psychotherapy with his previous mode of medical treatment, and to his own surprise found it of great advantage. After the completion of her psychological course, she never again showed any sign of calculus, and died from old age in 1925.

For years this woman had been compelled to nurse her mother, who suffered from renal colic. The mother had been so harsh as to make the daughter conceive a great dislike for her, and above all for the sick nursing she could not escape. At her mother's death she was tormented by guilt for having longed for freedom, which ended when she was later called to nurse her father in his last illness. One night he called for help. Being only half awakened out of a heavy sleep, the daughter did not move, but acted as if she had not heard his call, making the excuse to herself that her back was aching so much that she would be unable to lift her father's heavy, paralyzed body. When at last she went to him, she found him dead. Hence her avenging, destructive will would coöperate with her inherited kidney weakness to make her suffer the same kind of pain as the parents she had wronged.

The evidence from such cases leads to the conclusion that if the mind is healthy, it can do much to moderate a destructive bodily process, which can be produced or intensified if the mind is morbid. If the body is healthy, on the other hand, it may long withstand the morbid purposes of the will; but if

the body is diseased, it may dangerously intensify the conscious or unconscious will of the sick soul. There should, therefore, be no absolute differentiation of diseases as purely psychogenic or functional and purely organic or structural. At most it appears that in some cases the organic factors preponderate or precede, while in others the power of a destructive will, with its morbific thought and feeling, comes first or foremost.

From this theory of disease follow some hopeful prospects for therapy, but certainly no panacea. When the recent discoveries about the will as a factor in health and safety from accidents are generally accepted, each case of sickness or accident should be examined, first by a qualified physician to diagnose the medical symptoms of the patient, and then by a specialist in psychology and ethics to discover the state of the patient's will. The physician should decide what medical treatment is needed; the clinical psychologist should undertake a course of psychological training when there is clear evidence of a destructive conflict of will that cannot be removed by suggestion in an untechnical talk.

In some cases both these tasks can be adequately performed by the same specialist, but for reasons of temperament and training, they are usually better performed by separate technicians. The competent physician has a more extroverted temperament, a habit of attending to concrete and palpable facts, and a manual dexterity that are very rarely combined with the more introverted temperament, the habit of attending to the unseen and the abstract, and the intuitive sensitivity that make the good psychologist. Life is too short and medical studies too long for the average doctor to acquire the knowledge of religion, ethics, sociology, anthropology, and psychology on which to ground a good technic for training the will, balancing the feelings, and directing the thoughts of the student.

When the will to escape responsibility is strong, it can prolong a morbid condition that it is powerless to cause. Groddeck, is, therefore, justified in thinking that many surgical cases need skilled psychological help. He writes:

> "In the case of a broken leg, for example, we shall apply the appropriate bandage and, generally speaking, that will be enough. Every now and then, however, we come across fractures which obstinately refuse to heal in spite of the most careful physical treatment, but which yield

> to measures that combine all possible physical skill with attention to the psychical situation.''

As another example of a condition that is basically organic, we may mention the menopause. Yet the mind may so react to this inevitable and irreparable loss as to produce gloom, depression, or despair. By submitting her will to a course of psychological training, a woman in this condition can learn the art of facing the future with interest and energy, using her creative will to find new cultural outlets to replace the lost feeling of power.

It has long been known that prolonged and excessive emotions of hate, fear, and guilt lessen resistance to toxins and bacilli, but there is still a serious shortage of technicians with time and training to handle such cases. In a paper read before the San Francisco Medical Society in 1928, Dr. Anita Mühl states that ''humiliation, fear with its allies, anxiety and worry, are associated with toxic thyroid, gastric ulcer, colitis, chronic spastic constipation, high blood pressure, increased metabolic rate; while hatred, anger, resentment, and humiliation are seen in the neuralgias, migraines, and many conditions dealing with joint pains and tensions''. Dr. Mühl has evidence to show that if persons with incipient tuberculosis could be freed of their conflicts, there would be fewer chronic cases to be seen. In his book, *The Biological Basis of Human Nature,* Professor H. S. Jennings wages war against the fallacy that if a disease or defect is hereditary, it cannot be influenced by the environment (pp. 147–49).

We conclude that some form of psychotherapy—or, as I prefer to term it, psychological training or personality training—is desirable when destructive tendencies appear, regardless of the nature and origin of any bodily symptoms that may be present. In many cases of chronic loss of function from accident, operation, or disease, where a cure is out of the question, the personality must be trained to regain hope and a sense of value. So long as a psychoanalysis, lasting many months or several years, was the best method for those who lack faith in the churches' methods, this kind of help was bound to be a luxury for the few. The shorter methods devised by Adler, Jung, and Stekel for shortening analysis, and the new dynamic technique developed by Rank, make it possible for many sick persons to get a healthier ideal of life which

prevents much needless suffering, hastens recovery from curable diseases, and allows acceptance of inevitable ills.

If psychotherapy were to become a mere branch of medicine, there would be small hope of supplying the present need. The medical psychiatrist cannot afford to take many of the cases for which the general physician has neither the desire nor the capacity. But there is as little reason to limit the practice of psychological training to physicians as to require that all ministers of religion take a medical degree. The ability to make a diagnosis or to prescribe medical treatment does not enter into the theory or technique of personality training. The psychologist who is personally fitted for the work and adequately trained can dispense with the luxury of a medical degree with as good a technical conscience as the teacher in college and school.

Psychotherapy has suffered by its association with medical theory and technique. Psychiatry means cure of the soul. It is essentially a priestly, ministerial, and educational function. For a time the medical psychiatrists were forced to take over some sick souls that the churches had failed to cure. But their medically desirable bias inclined them to use such extreme means as work cures, rest cures, and hypnosis; to aim chiefly at the removal of obvious symptoms; and to deny the need of psychotherapy when organic causes were discoverable, primary or dominant.

The foregoing considerations seem to justify the following program in order that practice may catch up with knowledge on this subject.

1. The medical profession should be educated to suggest some method of psychological training in cases of disability and disease when it appears that the sufferer lacks enough faith in any organized form of religion to fortify his will to live and to supply the strength to overcome the traumatic events.

2. The already overloaded curriculum of medical training should be relieved, and neurologists and psychiatrists set free to devote their time to the medical side of psychiatry, by the recognition and use of non-medical psychologists, and by the endowment of mental-hygiene bureaus for cases that cannot afford the lowest fees that properly trained non-medical technicians must charge.

THE PLACE OF THE PSYCHIATRIST IN A STATE EDUCATION DEPARTMENT OR SCHOOL SYSTEM *

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DURING the past few years, progressive schools and school systems the country over have been utilizing, or have keenly felt the need of utilizing, psychiatric help and guidance in dealing with the manifold problems relating to the healthier adjustment of both child and teacher to everyday school life.

When we reflect for a moment that the fundamental objective of education in its broader meaning is to prepare each child for life as he has to meet it, not merely to teach him the three r's; when we frankly face the fact that no small percentage of our children and youths present personality difficulties and behavior problems that often have their roots, not only in physical ill health, but frequently in varying degrees of mental ill health, in many cases engrafted on constitutional weaknesses, mental retardation or acceleration, poor habit training, failure of the school to recognize and shape the school's curriculum to the individual child's needs, disharmony in the home atmosphere, as well as a host of other important factors—the wonder is that supposedly progressive educators have so long deferred utilization of the well-trained psychiatrist. This naturally leads us to the question of the function and duties of the psychiatrist in a school system or department of education.

It is desirable, during his period of orientation, that the psychiatrist gain a very definite point of view and a primarily inquiring attitude, in order that he may adapt his contribution, not only to the practical needs and situations of the local schools, department, communities, and state, but also to the broader general principles of his own function in this most

* The author is greatly indebted to Dr. Adolf Meyer for many constructive criticisms and helpful suggestions.

important field of work. Thus a base-line policy of inquiry and definition is an essential prerequisite to marshaling the material into a workable plan.

Any formulation of the duties of the psychiatrist must be taken in a very relative sense. He must be allowed a high degree of elasticity in functioning, since the approach to and the work in his particular field of contribution are so complex and multiform, calling not only for a thorough general and special medical and clinical training, but also for critical, trained common sense. As far as possible, he should be given a free hand to shape his own program. He should share the common-sense practice of the educator, but should define his own specific responsibilities, reserve for himself problems of personality difficulties and cognate interests, and formulate his means of contribution, being careful not to give common-sense data an exaggerated professional nimbus. What the psychiatrically trained physician can contribute should be fairly distinctive and yet essential in its way for the school.

The prime task of the psychiatrist of a department of education is *educational*. The sick child belongs to his family physician, the department of mental hygiene, the hospital, or the private clinic, where competent medical diagnosis and treatment can be carried out. The school psychiatrist, while intensely interested in the treatment and study of the child, must limit himself to what the school can derive from his guidance. However, wherever possible, he should also concern himself with sharing in the prevention and treatment of absences from school and difficulties of behavior.

The school should learn to utilize and coöperate with the family physician and the various dispensary and other clinical facilities at hand for consultations and treatment. These, in addition to the traveling child-guidance clinics of the department of mental hygiene, and occasional school clinics for teachers, student teachers, and others held in conjunction with the latter department, could be utilized most effectively as educational centers. Here school-teachers, teachers-in-training, parents, nurses, school medical inspectors, health teachers, social workers, and other interested persons could gain first-hand information and working knowledge of how be-

havior and personality difficulties and problems arise, and how they can be recognized in their early stages and treated or prevented.

Teachers' conferences offer a splendid opportunity for psychiatric participation. Here the physician could be effective in bringing home the facts of cases that are problems to teachers and in pointing out how these facts can be utilized in the handling of the cases.

As early as possible, the psychiatrist should visit all parts of the state and schools of various kinds, so as to give an introduction to the principles of mental hygiene from the teachers' angle and to inculcate a psychiatrically intelligent attitude.

In order to be available for such functioning, the psychiatrist of the state education department should not tie himself to the responsibility of running a clinic. Nevertheless, he might very profitably give occasional clinics to school-teachers and teachers-in-training as a most effective means of teaching the fundamental principles and practices of common-sense psychiatry as it figures in the school. In progressive localities, which feel the need and advantage of setting up their own child-guidance clinics (a point of view that should be fostered, providing the prerequisite local facilities for carrying out recommendations are available) the psychiatrist can be of great assistance in sharing in the establishment of a basic set-up, in guiding the policy and actual functioning of the clinic, and in providing for the best utilization of local clinical and welfare agencies as well as other helps.

The psychiatrist should bring to the fore the general common-sense character of much that figures as mental hygiene. It must be our ideal in mental hygiene to go to the heart of a situation without conjuring up alarmist ideas and visions. The primary need is for interest in and work with personality diffiulties and problems for their own sakes first and foremost, without too much emphasis upon preventing criminality and insanity.

It is of prime importance that the psychiatrist focus his attention on the classroom and make contacts with those who are working with the child. The writer does not wish to minimize the great contribution of talks, lectures, published

articles, and other publicity and informative methods, but these are secondary and complementary to the immense educational contribution of concrete clinical and classroom demonstration. The adjustment of the child to the school and of the school to the child should be the chief topic; the adjustment to life is the broader issue. Training for character and citizenship must be incidental.

In an education department it should become the psychiatrist's desire to *extend* his familiarity and experience with teaching to the educational organization of the schools. On the other hand, his medical-psychiatric training, which reaches beyond the ordinary school problems, should be utilized in its proper setting, but not thrust in—as sometimes has been done—as the only concern.

In as much as teachers and parents and psychologists have to be dealt with, it will be one of the school psychiatrist's problems to formulate the medically obtained data in such a way that the educationally useful material will stand out in a helpful manner.

In offering this formulation, the writer is fully aware of its many shortcomings and the omission of many data that might profitably be considered and discussed under such a topic. Nevertheless, in this short article, his prime object was to strike rock bottom and to outline some of the fundamental functions of the well-trained psychiatrist in any state education department or school system. To be more specific without having at one's disposal a great number of pertinent facts would be to invite gratuitous hazards. Specific functions should be more or less determined by local needs, practical situations, and the trained common sense of the psychiatrist. The most important thing is to lay a sound base-line policy for coöperative functioning and the best utilization of the assets and opportunities at hand.

ESSENTIAL TECHNIQUES IN THE ANALYSIS OF THE RELATIONSHIP OF MENTAL DISEASE WITH AGE

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A CLOSE relationship exists between age and the incidence of mental disease. As is common knowledge among psychiatrists, mental disorders increase in importance with the gradual aging of the nervous system. Resistance lessens with advancing years. This fact is illustrated by the data presented in Table I (page 762), which gives the rates of first admissions to hospitals for mental disease in the United States during 1922, expressed in terms of the number per 100,000 of the general population *of the same age distribution.* The low rate for "Under 15 years", the rather rapid increase up to thirty years, and then the slow increase through middle age, with increasing importance in the older ages are to be noted.[1]

In rates involving all ages, considerable discrepancy occurs due to the fact that such rates are usually based on total populations. This is the almost universal procedure. It is the purpose of the present analysis to indicate the lack of validity of the usual presentation of such data in terms of the general population. As has been pointed out, mental diseases are primarily diseases of adulthood. Hence rates of mental disease computed in terms of the total population are no more suitable for careful analysis than are birth rates compiled on the same broad basis.

From even a casual inspection of the data presented in Table I, it is evident that the amount of mental disease

[1] Here, as in all clear-cut presentations of the statistical significance of mental disease, rates are utilized rather than actual numbers. Only in such practical problems as those involved in providing hospital facilities are the number of the mentally diseased truly significant. From the social point of view, it is rather the proportion of such persons expressed in terms of population groups that portrays the situation adequately.

under fifteen years of age is insignificant, amounting to less than two cases out of every 100,000 of the child population, or, expressed in percentages, less than one-tenth of 1 per cent. On the other hand, almost one-third of the population of the United States is less than fifteen years old. Consequently results based on the *total population* are considerably lower than they would be if the data were more

TABLE I.—NUMBER OF FIRST ADMISSIONS TO HOSPITALS FOR MENTAL DISEASE DURING 1922, PER 100,000 OF THE GENERAL POPULATION OF THE SAME AGE.*

Age	*Total first admissions*
Under 15 years	1.4
15 to 19 years	32.3
20 to 24 years	66.8
25 to 29 years	90.7
30 to 34 years	104.8
35 to 39 years	107.7
40 to 44 years	115.4
45 to 49 years	111.4
50 to 54 years	113.9
55 to 59 years	113.9
60 to 64 years	126.9
65 to 69 years	145.4
70 to 74 years	186.3
75 to 79 years	215.2
80 years and over	276.4

* Source: *Patients in Hospitals for Mental Disease, 1923*, published by the Bureau of the Census, U. S. Department of Commerce. p. 31.

correctly computed. For example, there were 68.2 first admissions to hospitals for mental disease during 1922 per 100,000 of the general population of the United States. When the simple refining device is utilized of computing the rate on the basis of the population fifteen years of age and over, it becomes 99.4 [1] per 100,000, an increase of almost 50 per cent. Perhaps impracticable in the case of Census publications, the computation of rates of mental disease on the basis of population groups fifteen years of age and over is an important step in the more adequate analysis of the prevalence of mental disorders at the present time. Disregard of this simple device results in an understatement of the true situation.

An issue may be raised as to the arbitrariness of the selection of the population fifteen years of age and over as the basis of computation. Further examination of the table

[1] Utilizing the total population as of 1920.

indicates that from fifteen to nineteen years of age there is already a significant amount of mental disease. Therefore, for general presentation, an age basis sufficiently wide to include practically the entire range of incidence is to be regarded as the most desirable. An age basis of fifteen years of age and over excludes the childhood years, which are

TABLE II.—DISTRIBUTION OF SELECTED PSYCHOSES OF FIRST ADMISSIONS TO NEW YORK STATE HOSPITALS IN 1920, BY AGE PERIODS, PER 100,000 OF THE GENERAL POPULATION OF THE SAME AGE.*

Age	*Senile*	*With cerebral arterio-sclerosis*	*General paralysis*	*Alcoholic*	*Manic-depressive*	*Dementia praecox*	*Involution melancholia*
Under 15 years	...	...	...	...	.2	.2	...
15 to 19 years	...	...	.5	...	9.2	15.2	...
20 to 24 years	...	...	1.0	.2	11.6	33.8	...
25 to 29 years	...	...	2.8	.7	15.9	42.1	...
30 to 34 years	...	...	12.3	1.7	16.7	34.5	...
35 to 39 years	...	...	19.3	2.3	14.4	34.1	.4
40 to 44 years	...	.3	20.7	3.0	11.7	27.7	3.4
45 to 49 years	.8	2.9	22.0	2.6	9.7	20.2	9.1
50 to 54 years	1.1	9.2	20.5	3.6	9.0	15.3	12.2
55 to 59 years	3.3	22.4	18.8	2.8	8.2	11.8	11.3
60 to 64 years	21.3	37.9	10.8	3.2	8.6	6.1	11.1
65 to 69 years	50.2	53.6	4.8	.5	8.6	3.8	6.2
70 years and over ...	158.1	44.4	...	.4	1.1	1.4	1.1

* Sources: U. S. Census, 1920, Vol. II, Ch. III, Table 13; Thirty-second Annual Report of the (New York) State Hospital Commission (July 1, 1919, to June 30, 1920), Table 16, pp. 308-311.

practically free from serious cases of mental disease and the inclusion of which results in an inaccurate description.

This method of refinement is adequate, however, only for general results where there is no need of the highest possible degree of control. Each type of psychosis has its characteristic age distribution, as shown in the data for New York State presented in Table II. Wherever the individual clinical classifications are utilized, therefore, more careful methods must be employed.

Let us be concrete. Senile psychoses and cerebral arteriosclerosis are diseases of old age. To compute the rates for these diseases even on the basis of the population fifteen years of age and over would be highly inaccurate. From an analysis of the age distribution of first admissions to hospitals for mental disease with senile psychoses, it is clear that an adequate base is the population fifty-five years of age and over.

To illustrate the importance of the controlled selection of the population basis in computing rates for a given psychosis, data for New York State for first admissions with senile psychoses from 1910 to 1927 may be taken. When the population fifteen years of age and over (already a great refinement over the total population) is taken as the basis of computation, the rate of first admissions is found to vary from 7.8 to 9.5 per 100,000 population within the period studied. When the more accurate age distribution of fifty-five years and over is utilized, the rate is found to vary within the limits of 51.7 to 64.7 per 100,000 population. Actually, therefore, senile psychoses are found to occur with much greater frequency than a casual study of first admissions would indicate. The relative frequency of the hospitalization of persons suffering from this particular malady becomes clear-cut. Only by such methods of age refinement can its true general significance be determined. This method offers a sound basis for comparisons of the total rate of incidence of senile psychoses from year to year, a form of analysis that becomes absurd when based on the total population.

For cerebral arteriosclerosis, the age span of forty-five year of age and over may be taken as the corrected basis of population for general rates. Before that age period the incidence of cerebral arteriosclerosis, as measured in terms of hospital first admissions, is insignificant. This refinement in method yields results comparable to those found in the case of senile psychoses. The true trend of this type of abnormality is revealed.

Similarly, the population basis must be regulated in accordance with the age distribution of the other psychotic classifications, only the numerically most important of which are given in Table II. Among them may be cited general paralysis, which involves comparatively few cases before twenty-five years of age. The same observation is true with regard to alcoholic psychoses. It might even be advisable to determine the upper age limit as well—sixty-five to sixty-nine years in the case of general paralysis, sixty to sixty-four years in the case of alcoholic psychoses. On the other hand, the percentage of the general population sixty-five years of age and over is relatively small, so that the major error has been corrected when the basis of population is taken as

twenty-five years of age and over rather than fifteen years of age and over.

On the other hand, dementia praecox and manic-depressive psychoses have such wide distributions over the total age span that computation of individual rates on the wider basis of the population fifteen years of age and over appears most practical. Their fairly consistent importance throughout adulthood is evident.

Involution melancholia is also of particular interest due to its restricted age distribution. An analysis in terms of the population forty years of age and over would appear to give the most satisfactory results.

Thus, not only should the student of the quantitative aspects of mental disease adopt the more accurate base, the total population fifteen years of age and over, but also, in dealing with specific psychoses, he should take careful account of the incidence of each disease classification at the characteristic age periods. When this is done, the investigator has not only a more accurate statement of actual conditions, but also a sounder basis for the prediction of the trends of the various psychoses.

As statistical analysis of the existing data on mental disease becomes more intensive, it is essential that a corrected age basis be utilized. No longer can the student of the incidence of mental disease be content either with a mere statement as to the importance of the age factor or with a totally unrefined basis for the computation of rates. The techniques of refinement presented here have an obvious value due not only to their simplicity, but also, primarily, to their general adequacy. It is only as the more complicated problems in connection with the numerical aspects of mental disease are analyzed that a statistical technique such as the method of standard population need be utilized. Hence this method will not be discussed here. The methods presented in the present study, however, are deemed so important that it may be categorically stated, first, that any analytical study of the rate of incidence of a specific psychosis is not complete unless it definitely takes into account the specific age distribution; and, second, that general rates of mental disease based on the total population are inaccurate and unreliable and should be superseded by the refining techniques suggested above.

MENTAL DISEASE AMONG JEWS

A SECOND STUDY* WITH A NOTE ON THE RELATIVE PREVALENCE OF MENTAL DEFECT AND EPILEPSY

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ON the basis of very inadequate data, it has been often asserted that Jews have a higher rate of mental disease than non-Jews. Some plausibility was lent to this belief by the fact that Jews, especially the great mass of Jews from eastern Europe, appear to be excessively emotional in their behavior, and it followed, almost like a corollary, that an excessive display of emotion must be associated with a greater tendency toward mental disease. This hypothesis also fitted in with the facts of Jewish history, from which it was deduced that mental instability would be a likely consequence of Jewish modes of living in past centuries. Such theories, despite their apparent plausibility, must, nevertheless, be put to the test of verification, and it is a surprising fact that when this is done, the first discovery is the necessity of discarding most, if not all, of the alleged statistics on the subject. The inadequacy of these data has been discussed in some detail in a previous study,[1] in which the subject of the relative rates of mental disease among Jews and non-Jews was approached through an analysis of first admissions to hospitals for mental disease in the state of New York. It is generally agreed that in a state with adequate facilities for treatment, and with a liberal policy toward the admission of patients, the number of first admissions constitutes the best index of the prevalence of mental disease. For this reason, the data for the state of New York, which included a complete count of all first admissions and were free of any selective influences, furnished a particularly important

* A previous study by the author, *The Prevalence of Mental Disease among Jews*, appeared in MENTAL HYGIENE, Vol. 14, pp. 926–46, October, 1930.

[1] See pp. 928–29 of the study referred to in footnote above.

contribution to the analysis of the racial element in mental disease.

It was shown [1] that in 1920 the rates of first admission to the New York civil state hospitals were 40.7 per 100,000 population among Jews and 67.7 per 100,000 among non-Jews. In 1927 the rates of first admission were 42.3 and 75.1 among Jews and non-Jews respectively. In order to eliminate the influence of degree of urbanization, a further analysis was made with respect to first admissions in 1925 from New York City to all classes of institutions, public and private, for the treatment of mental disease, and it was shown that the rates of first admission were 40.0 and 78.4 among Jews and non-Jews respectively. Here, therefore, was striking evidence that, contrary to the oft asserted claim, Jews had a markedly lower rate of mental disease than non-Jews.

These results are of particular importance, in as much as they are based upon an analysis of a very large population which in 1925 included 1,713,130 Jews.[2] The great variety of racial groupings in the United States, and the important consequences that flow from such an intermingling, make studies of racial differences of great significance. It is well, therefore, that, when possible, additional evidence be presented as to the prevalence of mental disease among a group with so high a degree of relative homogenity as the Jews. The rates in the state and in the city of New York may be compared with similar data for the states of Massachusetts and Illinois, and it will be shown that the results for New York are fully confirmed by those in the latter states.

The racial classification of first admissions to hospitals for mental disease in Massachusetts are given in the annual reports of the Massachusetts Department of Mental Diseases. In order to rule out fluctuations in admissions in a single year, first admissions for the years 1926 to 1928 inclusive were combined, and the average centered at 1927. In the latter year the Jewish population in Massachusetts was estimated at 225,634.[3] The average annual number of Jewish first

[1] *Ibid.*, pp. 935 and 940.

[2] See *Jewish Communal Survey of Greater New York*, First Section: *Studies in the New York Jewish Population*. New York: Bureau of Jewish Social Research, 1928. pp. 12–16.

[3] See *American Jewish Year Book*, Vol. 30, 1928–1929, p. 102.

admissions was 70.3. The rate of first admission was, therefore, 31.2 per 100,000 Jews. The non-Jewish population, which was estimated at 3,914,163, furnished an average of 2,879.3 first admissions, making a rate of 73.6 per 100,000. In Illinois the Jewish population was estimated at 345,980 in 1927.[2] According to the annual reports of the Illinois Department of Public Welfare, the average number of Jewish first

TABLE I. JEWISH AND NON-JEWISH FIRST ADMISSIONS TO THE MASSACHUSETTS STATE HOSPITALS FOR MENTAL DISEASE, 1926 TO 1928 INCLUSIVE, CLASSIFIED ACCORDING TO PSYCHOSES, SHOWING PERCENTAGE DISTRIBUTIONS AND AVERAGE ANNUAL RATES OF FIRST ADMISSION PER 100,000 POPULATION

	Jews			*Non-Jews*		
Psychoses	Number	Per cent	Rate per 100,000 population	Number	Per cent	Rate per 100,000 population
Traumatic	1	0.5	0.1	30	0.3	0.3
Senile	7	3.3	1.0	854	9.9	7.3
With cerebral arteriosclerosis	8	3.8	1.2	1,194	13.8	10.2
General paralysis	15	7.1	2.2	609	7.1	5.2
With cerebral syphilis	2	0.9	0.3	61	0.7	0.5
With Huntington's chorea	1	0.5	0.1	10	0.1	0.1
With brain tumor	1	0.5	0.1	10	0.1	0.1
With other brain or nervous diseases	7	3.3	1.0	163	1.9	1.4
Alcoholic	1	0.5	0.1	611	7.1	5.2
Due to drugs and other exogenous toxins	...	...	...	29	0.3	0.2
With pellagra	...	...	...	5	0.1	*
With other somatic diseases	4	1.9	0.6	331	3.8	2.8
Manic-depressive	47	22.3	7.0	984	11.4	8.4
Involution melancholia	3	1.4	0.5	230	2.7	2.0
Dementia praecox	77	36.5	11.4	1,905	22.1	16.2
Paranoia or paranoic conditions	1	0.5	0.1	224	2.6	1.9
Epileptic psychoses	3	1.4	0.5	159	1.8	1.4
Psychoneuroses and neuroses	...	...	...	94	1.1	0.8
With psychopathic personality	3	1.4	0.5	72	0.8	0.6
With mental deficiency	9	4.3	1.3	256	3.0	2.2
Undiagnosed psychoses	18	8.5	2.7	637	7.4	5.4
Without psychosis	3	1.4	0.5	170	1.9	1.4
Total	211	100.0	31.2	8,638	100.0	73.6

* Less than 0.05.

admissions to hospitals for mental disease in that state was 102.3. The rate of first admission among Jews was, therefore, 29.6 per 100,000 population. The 6,905,814 non-Jews had an average of 4,436.3 first admissions, making a rate of 64.2 per 100,000. In these two states, therefore, the rates of first admissions among Jews were only 42.4 and 46.1 per cent, respectively, of the corresponding rates among non-Jews.

The first admissions in Massachusetts classified according to psychoses are shown in Table I.

[2] *Ibid.*

Of the 211 Jewish first admissions in 1926–1928 inclusive, 77, or 36.5 per cent, were cases of dementia praecox. The manic-depressive psychoses comprised the next largest group, with 47 first admissions, 22.3 per cent of the total. Among non-Jewish first admissions, on the other hand, dementia praecox, though again the largest category, included only 22.1 per cent of the cases. The manic-depressive psychoses dropped to a percentage of 11.4, and were exceeded by psychoses with cerebral arteriosclerosis, which included 13.8 per cent of the total. The two leading functional disorders, manic-depressive psychoses and dementia praecox, therefore, account for 58.8 per cent of the Jewish first admissions as compared with 33.5 per cent among the non-Jews. On the other hand, general paralysis, senile psychoses, and psychoses with cerebral arteriosclerosis account for only 14.2 per cent among the Jews as compared with 30.8 per cent among non-Jews.

Similar results are shown in general by the first admissions in Illinois, which are classified in Table II.

TABLE II. JEWISH AND NON-JEWISH FIRST ADMISSIONS TO THE ILLINOIS STATE HOSPITALS FOR MENTAL DISEASE, 1926 TO 1928 INCLUSIVE, CLASSIFIED ACCORDING TO PSYCHOSES, SHOWING PERCENTAGE DISTRIBUTIONS AND AVERAGE ANNUAL RATES OF FIRST ADMISSION PER 100,000 POPULATION

	Jews			*Non-Jews*		
Psychoses	Number	Per cent	Rate per 100,000 population	Number	Per cent	Rate per 100,000 population
Traumatic	1	0.3	0.1	42	0.3	0.2
Senile	12	3.9	1.1	973	7.3	4.7
With cerebral arteriosclerosis	30	9.8	2.9	1,636	12.3	7.9
General paralysis	33	10.7	3.2	1,638	12.3	7.9
With cerebral syphilis	...	...	...	62	0.4	0.3
With Huntington's chorea	...	...	...	27	0.2	0.1
With brain tumor	...	...	...	2	*	*
With other brain or nervous diseases	2	0.7	0.2	187	1.4	0.9
Alcoholic	3	1.0	0.3	1,014	7.6	4.9
Due to drugs and other exogenous toxins	...	...	...	28	0.2	0.1
With pellagra	...	...	...	3	*	*
With other somatic diseases	9	2.9	0.9	314	2.4	1.5
Manic-depressive	19	6.2	1.8	647	4.9	3.1
Involution melancholia	8	2.6	0.8	133	1.0	0.6
Dementia praecox	142	46.3	13.7	3,311	24.9	16.0
Paranoia or paranoic conditions	1	0.3	0.1	83	0.6	0.4
Epileptic psychoses	4	1.3	0.4	272	2.1	1.3
Psychoneuroses and neuroses	3	1.0	0.3	199	1.5	1.0
With psychopathic personality	3	1.0	0.3	38	0.3	0.2
With mental deficiency	12	3.9	1.1	362	2.7	1.8
Undiagnosed psychoses	17	5.5	1.6	1,070	8.1	5.2
Without psychosis	8	2.6	0.8	1,268	9.5	6.1
Total	307	100.0	29.6	13,309	100.0	64.2

* Less than 0.05.

Of the 307 Jewish first admissions in the years 1926–1928, 142, or 46.3 per cent, were cases of dementia praecox. The manic-depressive psychoses, however, were a surprisingly small group, comprising only 19 cases, or 6.2 per cent of the total. Psychoses with cerebral arteriosclerosis and general paralysis included 9.8 and 10.7 per cent respectively. Among the non-Jews, dementia praecox was the leading category, with 24.9 per cent of the total first admissions. This percentage was little more than half that among the Jews. Psychoses with cerebral arteriosclerosis and general paralysis each comprised 12.3 per cent of the non-Jewish first admissions. If we combine the several categories, as in the case of Massachusetts, we find that the functional group comprised 52.5 per cent of the Jews, and only 29.8 per cent of the non-Jews, whereas the organic group included 31.9 per cent of the non-Jews and 24.4 per cent of the Jews. These results, therefore, confirm the usual qualitative differences among Jewish and non-Jewish insane shown in previous studies.

Table I also gives the average annual rate of first admissions in Massachusetts in the several groups of psychoses. In every important psychosis the Jews have lower rates of first admission than the non-Jews. In the senile psychoses and in psychoses with cerebral arteriosclerosis, the Jews have rates of only 1.0 and 1.2 per 100,000 as compared with rates of 7.3 and 10.2, respectively, among non-Jews. In general paralysis, the Jews and non-Jews have rates of 2.2 and 5.2 respectively. In the alcoholic psychoses, the rates are 0.1 and 5.2 respectively. In the important categories of the manic-depressive psychoses and dementia praecox, the Jews have rates of 7.0 and 11.4, compared with 8.4 and 16.2 respectively among non-Jews. In all the major psychoses, it is, therefore, evident that the Jews have lower rates of first admission.

These results are confirmed in Table II for the state of Illinois. In the senile psychoses, the rates are 1.1 and 4.7 for Jews and non-Jews respectively. In psychoses with cerebral arteriosclerosis, the rates are 2.9 and 7.9 respectively. In general paralysis they are 3.2 and 7.9. In the alcoholic psychoses, the rates are 0.3 and 4.9 respectively. In dementia praecox, the Jews have a rate of 13.7 compared with 16.0

among non-Jews. In the manic-depressive psychoses, the rates for both groups were unusually low, though the non-Jews again exceeded the Jews with a rate of 3.1 as compared with 1.8.

On first thought, it would appear possible that some of these differences might be the result of a more favorable age composition of the Jews. But it has been shown in a previous study that even in corresponding age groups the non-Jews have higher rates than the Jews. Thus Jewish first admissions from New York City aged sixty-five years and over had a rate of 155.6 per 100,000, whereas the non-Jews had a rate of 194.7.[1] It is thus impossible to explain away the differences in the senile and arteriosclerotic psychoses on this basis. On the other hand, it should be recalled that the Jews live in highly urbanized communities. If this factor were held constant in connection with the data for Massachusetts and Illinois, the rates among Jews would have been reduced in comparison with those among non-Jews.

The validity of the preceding conclusions depends upon the accuracy of the population estimates. No uncertainty exists as to the number of Jewish first admissions, as these are actual counts, not approximations. The population totals, however, are not enumerations, but estimates. If these had erred in excess, the true rates of first admission among Jews would be higher and those among non-Jews lower than those obtained above. In New York, however, the Jewish population, instead of being overestimated, was undoubtedly underestimated, owing to the method of estimation; consequently the true rates of first admission among Jews in New York City were even lower than those indicated in the earlier study.[2] The estimates of the Jewish populations of the states of Massachusetts and Illinois in 1927 were derived in part by a method of identification of individual Jews and in part by a study of school populations. The first method, which was used in smaller communities, consisted of direct enumeration of Jews by selected correspondents. Jews who had intermarried or who did not practice the Jewish faith were not included in the enumeration.[3] This method, therefore,

[1] See MENTAL HYGIENE, October 1930, p. 941.

[2] *Ibid.*, pp. 939–940.

[3] See *American Jewish Year Book*, 1928–1929, p. 115.

clearly underestimated the correct total of Jews in these communities. The second method, which was employed in large cities such as Boston and Chicago, depended upon an estimate of the number of Jewish school children. It was assumed that the ratio of the Jewish school population to the total Jewish population would equal a constant derived from a study of the entire population. This method has been tested on numerous occasions and compared with results arrived at by other methods, and the results have been found reasonably concordant.[1] We may, therefore, feel confident that an error in these population estimates, if any, would have tended, as in the case of New York City, to exaggerate rather than to underestimate the corresponding rates of first admission among Jews.

We may, therefore, feel assurance in asserting that the evidence of rates of first admission to hospitals for mental disease in Massachusetts and Illinois indicates that mental disease is less prevalent among Jews than among non-Jews, confirming the results previously obtained in New York. For this reason, we may say that all references to the alleged effects of consanguinity, persecution, and urbanization upon the mental health of the Jew are gratuitous. Until convincing statistical proof to the contrary is forthcoming, we must maintain that the belief concerning the peculiar tendency of the Jew to forms of mental disease—a belief largely perpetuated by Dr. Maurice Fishberg in his book, *The Jews*[2]—is of the nature of a superstition and as such should be relegated to oblivion.

II

The foregoing data permit us to make some estimates as to the probable relative prevalence of epilepsy and mental defect among Jews and non-Jews. It will be noticed that in Massachusetts the rates of first admission with epileptic psychoses were 0.5 and 1.4 per 100,000 population among Jews and non-Jews respectively. In psychoses with mental deficiency, the rates among the two groups were 1.3 and 2.2 respectively. In Illinois we find the same order. In the epi-

[1] *Ibid.*, pp. 170 and 171.

[2] *The Jews; A Study of Race and Environment.* New York: Charles Scribner's Sons, 1911.

leptic psychoses, the rates were 0.4 and 1.3 for Jews and non-Jews respectively. In psychoses with mental deficiency, the corresponding rates were 1.1 and 1.8. Now it is possible to make three assumptions concerning the ratio of the number of epileptic or feebleminded insane to the number of corresponding epileptics or feebleminded among Jews, as compared with similar ratios among non-Jews. The ratios among Jews may be greater than, equal to, or less than those among non-Jews.

Let x^1 represent the number of Jewish psychotic first admissions with mental deficiency, and x the number of Jewish first admissions with mental deficiency. Let y^1 and y represent similar numbers among non-Jews. On the first assumption, $\frac{x^1}{x}$ is greater than $\frac{y^1}{y}$. Let M and N represent the total populations of Jews and non-Jews, respectively. Then $\frac{x^1}{M} \div \frac{x}{M}$ is greater than $\frac{y^1}{N} \div \frac{y}{N}$. Now $\frac{x^1}{M}$ and $\frac{y^1}{N}$ represent the rates of first admissions in the group of psychoses with mental deficiency, and it has been shown that $\frac{x^1}{M}$ is less than $\frac{y^1}{N}$. Therefore $\frac{x}{M}$ (or the rate of first admissions with mental deficiency among Jews) must be less than $\frac{y}{N}$ (the corresponding rate among non-Jews). If we assume that $\frac{x^1}{M} \div \frac{x}{M} = \frac{y^1}{N} \div \frac{y}{N}$, it again follows that $\frac{x}{M}$ must be less than $\frac{y}{N}$, in order that the equation may hold true. Let us assume, finally, that $\frac{x^1}{M} \div \frac{x}{M}$ is less than $\frac{y^1}{N} \div \frac{y}{N}$. In this case the inequality may be true, if $\frac{x}{M}$ is less than $\frac{y}{N}$ within certain limits, but it is also true if $\frac{x}{M}$ is equal to or greater than $\frac{y}{N}$.

We see, therefore, that on the basis of the first two hypotheses, the rate of first admissions with mental deficiency would be less among Jews than among non-Jews. The third hypothesis favors a greater rate among Jews, though it still leaves open the possibility of a lower rate among them. Balancing, then, all the respective probabilities, we see that there is greater weight in favor of the probability that Jews have a lower rate of first admissions with mental deficiency (or epilepsy) than have non-Jews. Admittedly this approach cannot be conclusive; it is merely suggestive. To furnish a thoroughly satisfactory solution, we need data that go beyond even the statistics of admissions to institutions. For unlike hospitals for mental disease, state institutions for mental defectives and epileptics do not provide complete statistics or even representative samples of the several racial elements in the general population. Only a thorough analysis of large unselected samples of the populations would offer satisfactory evidence. I am, unfortunately, unable to discover any relevant material, based upon the application of mental tests, to appropriate populations of Jews, that would indicate the proportion of mental defectives among them. The Army results, for example, are inapplicable, first, because of the failure to differentiate between Jews and Russians, and, secondly, because of the selected age distribution of the group. Other studies fall short for equally valid reasons. In the absence of such direct evidence, therefore, the indirect results arrived at above are offered as a preliminary approach to the problem.

THE INTERNATIONAL PRISON CONGRESS OF 1930

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THE International Prison Congress which met in Prague in August, 1930, was the tenth of a distinguished series. The first congress was held in London in 1872, the ninth in London in 1925, and the 1910 meeting in Washington.

To judge by the proceedings of the London congress of 1925, the Prague conference seems to have been inferior to it in a number of respects. In the first place, some of the general addresses delivered by outstanding figures at the London congress were brilliant and provocative, while the general addresses of the Prague congress did not rise to that level. Viscount Haldane's penetrating speech at the London congress, for example, on the meaning of punishment will long remain a classic "philosophical challenge of the idea of the total abolition of punishment". Secondly, the London congress seems to have been managed more effectively in such matters as translations and interpretations than the Prague meeting.

Organization and Machinery of the Congress.—Preparation for the quinquennial congress is the chief activity of the Penal and Penitentiary Commission, to which the various governments appoint commissions. Official delegates were in addition designated by the various state and federal governments. The veteran secretary-general of the congress, Sir J. Simon van der Aa, as usual did his best to organize the vast enterprise as smoothly as possible. The American commissioner, Mrs. Caroline P. Wittpenn, gave unsparingly of her time and thought to make the congress a success. The topics for discussion were this year divided into four groups, each to be considered by a separate section: (1) Legislation, (2) Administration, (3) Prevention, and (4) Youth. Various specific questions, chosen largely by the permanent secretary-general

of the commission and the congress, had been submitted to specialists throughout the world, with an invitation that they prepare reports on the questions and submit them to the secretariat of the commission. These reports on each of the specific questions were turned over to a *rapporteur* chosen for each question, whose function it was to summarize them, critically comment on them, and weld them into a joint report. This was then presented at the various sections for debate, and formed the basis for appropriate resolutions. The resolutions, if adopted, were on the next morning presented to the general assembly for debate, amendment, and final adoption or rejection. In addition to these debates, the general assembly was each day addressed by some prominent person.

Naturally, those who conduct the congress are eager to improve it at each succeeding session. Hence it is not amiss to stress two or three practices in connection with the above procedure that might be improved:

1. Copies of the reports of the different experts on the various questions submitted to them, in French, were mailed to the official delegates to the congress several months before the meeting. While we would have preferred English translations, there was sufficient time before the congress for one to extract the gist of the various contributions. But the more important reports of the various *rapporteurs* were not sent to the delegates in advance. They were read at the section meetings. This made it very difficult for those without an excellent command of French to be in a position to debate the subjects presented. Most of the interpreters at the congress were disappointing. A delegate would argue heatedly for a long time, and the interpreter would try to summarize what he said in a few minutes, and not always correctly.

2. Another inadequate feature of the machinery of the congress was the fact that the sections were so arranged as to permit of attendance at only one section meeting a day, unless a delegate wanted to go from one meeting to another while they were still in session. That this situation could be remedied is shown by the fact that the International Mental Hygiene Congress was so organized as to give an opportunity for attendance at several complete section meetings each day.

The American delegation arranged to meet each morning before the sections opened in order to arrive at some mutually agreeable policy regarding the questions to be discussed.

Let us now consider those questions and resolutions of the congress which are of major interest.

Legislation.—In this section the first question considered is of importance:

> "The adoption of the policy of measures of rehabilitation and prevention (*mesures de sûreté*) having become more general, which of such measures are the most suited to the purpose, and how may they be classified and systematized?"

It is first necessary to explain that on the Continent the phrase "*mesures de sûreté*" has in recent years come into use to designate a variety of measures of control and rehabilitation of the offender, in addition to and beyond the classical system of punishments. Thus the equivalent of our probation, as well as such practices as the internment of the criminal insane, for example, are embraced under the French term, which one might briefly translate as "safety measures". The *rapporteur* on this question was the very able *procureur général* of the highest court of Belgium, Professor Cornil.

After considerable debate regarding details of language, the following resolution was unanimously adopted by the section:

> "It is essential to round out the system of penalties by a system of measures of security, to guarantee the safety of the public in cases where a punitive sentence is inapplicable or insufficient.
>
> "Measures of safety have as their aim the amendment or elimination of the delinquent or the removal from him of the possibility of further criminality. They are applicable by the courts.
>
> "Without considering safety measures concerning juveniles, the following measures are particularly to be recommended.
>
> "*A. Measures in deprivation of liberty:* 1. Internment of insane or abnormal criminals presenting a social danger, with the view, as far as possible, of their cure and adaptation to life in freedom. 2. Curative internment of alcoholic and drug offenders. 3. Internment of beggars and vagrants with a view to adapting them to work. 4. Internment of habitual criminals with a view to their removal (*disablement*), but without the chance of their betterment being lost in the régime to be applied to them.
>
> "Incarceration (of these various types) is to be in special establishments.
>
> "*B. Measures not implying deprivation of liberty:* The most effective of these measures is social oversight (*le patronage*) or supervised liberty.

> Warning as to good conduct (binding over to keep the peace), interdiction of the exercise of certain trades or professions the practice of which was the cause of the delinquency, the prohibition of visiting places where intoxicating drinks are sold may give useful results. They should be combined with supervision.
>
> "*C. Measures dealing with property:* It is necessary to envisage genuine safety measures looking to the confiscation of objects dangerous to the public security or to rendering them inoffensive.
>
> "Only in exceptional cases can the putting into effect of these (above) measures of security be suspended. When it is, their place must be taken by social oversight (*le patronage*)."

This is a program to which the American delegates were of course in general willing to subscribe, taking into account modifications necessary because of differences of laws, practices, and traditions. The unique feature of the Continental practice in regard to these matters seems to be the sharp separation of punitive measures from those of social security. The Massachusetts defective-delinquent law would be called a "measure of security" under this distinction. Perhaps it would bring more order into our punitive and welfare legislation if the various means for dealing with different types of offender were classified under these two heads of corrective and medico-educative, the distinction being based on the legal differentiation of criminal and civil processes or of sentence and commitment.

Let us consider this important resolution in detail. The United States, and particularly New York and Massachusetts, have long been in the vanguard of the movement to establish special institutions for various major types of offender. As a result of Dr. Bernard Glueck's study of the inmates of Sing Sing Prison in 1917, a clearing house and five specialized correctional institutions were proposed for New York: two industrial prisons, one farm, one institution for the criminal insane, and one for defective delinquents. Workers on the Harvard crime survey have long had in mind a similar proposal, with certain modifications.

There are two types of offender—chronic alcoholics and vagrants—for whom the Prague resolution makes provision and in the treatment of which we in America are woefully inadequate. The chief reasons, I believe, are two: In the first place, public opinion, including that of legislators, must still be educated to regard these problems from a medico-

social point of view rather than from the traditional sentimental or good-natured approach. Our treatment of the problem of chronic drunkenness is a disgrace. The "cat-and-mouse" procedure of arresting and rearresting these persons for ten, twenty, one hundred, or more times—often having them released by probation officers without court appearance or investigation of their problems, or fined or placed on superficial "probation", or committed for a few weeks of loafing to a jail or state farm without thorough study of the individual case and its biological and social implications—is in large measure due to the popular belief that "drunkenness isn't anything serious after all". But, not to mention the chronic alcoholic himself, the drunkard is often the villain in family tragedies of desertion, non-support, assault. The second reason for our unsatisfactory handling of this social problem is that it is peculiarly baffling. Not enough thought and research of a medical, psychiatric, and social nature have been given to it, and not enough experiment has gone into methods of individual and social reorientation of alcoholics and vagrants. Probably commitment of chronic alcoholics and vagrants to a special institution and farm for a wholly indefinite period as a "measure of security", rather than sentence for brief, fixed terms, is the necessary basis for an attack upon this problem; and the experimental and laboratory features of such an institution should comprise its heart. It is only fair to say about the various provisions of the above resolution that certain communities in this country have gone farther in the application of psychiatry and psychology to penal affairs than most European countries.

In the matter of measures not implying deprivation of liberty—that is, probation and parole—one could dilate at great length. The forthcoming Harvard crime survey has been attempting to make a detailed evaluation of such services with a view to further improvement of these great instrumentalities of American inventiveness. They present numerous problems of organization and personnel, of the quality of investigative and supervisory work, of the proper selection of probationers and parolees.

Administration.—The first question before the section on administration was as follows:

"Within the limits of existing laws, what should be the rules governing the carrying out of punishments on the basis of the idea, already adopted, of the reform and reclamation of prisoners?

"Can this, for example, be achieved by (a) collaboration of private individuals during the execution of punishment; (b) selecting and recompensing the work imposed on the prisoners; (c) recreational measures which, through their educational value, would not interfere with the character of the punishment?"

The resolutions adopted after considerable heated debate were as follows:

"The better to assure the protection of society, the execution of the sentence should contribute to the education and regeneration of the criminal by all the existing means of pedagogy. It should develop the offender physically and embrace his moral and intellectual education, using the crimino-biological examination and the gradual classification of prisoners on the basis of the influence of education upon them.

"The aim sought demands, in addition: (a) the collaboration of volunteer workers, chosen for their personal qualities of mind and heart; (b) work which corresponds to the aptitudes of the prisoner and which should be rewarded according to his conduct and amount of labor, a suitable portion of the prisoner's remuneration to be turned over to those persons dependent on him for support; (c) means of intellectual and physical recreation, adapted to the customs of the different countries, a matter meriting much more attention than it has thus far received."

Of course we are all in sympathy with the general features of a resolution of this kind. The only surprising thing is that as late as 1930 they should have been live and debatable issues at an international congress of penal experts. A word as to the details of the resolution. First, the rôle of volunteer workers in institutional and other fields has not yet been sufficiently defined. It is very probable that carefully selected, intelligent, and sympathetic volunteers, guided and supervised in their work, have an important place in any correctional program. Secondly, vocational guidance and adequate remuneration of prisoners are also greatly needed. Thirdly, the place of recreation in the institutional curriculum and the best means of constructive recreation have also not been defined with sufficient clarity. Penologists are beginning to agree, however, that forms of recreation that inmates help to plan and in which they actively participate are superior to negative recreational programs. One of the contributors at the congress spoke very enthusiastically, for example, of the value of having inmates produce plays, as a means of

emotional outlet and education. This might be further experimented with.

The second set of questions raised in this section were the following:

> "How should the professional and scientific training of the prison staff, both for administration and supervision, be organized?
>
> "What qualifications should be demanded, on one side, and what advantages should be offered, on the other, in order to obtain the best possible persons for this service?"

This is perhaps the most important subject in the field, as indeed it is in practically all of life's endeavors. We, in America, are too prone to stress architecture or "systems" in prison administration; yet if one had to choose between buildings and "systems" on the one hand, and adequate personnel on the other, one would probably vote for the latter. The resolution adopted on the subject of personnel is as follows:

> "All officers of penal administration should be specially trained and developed (*formés*) for their particular functions.
>
> "The higher officials should possess an advanced education. It is essential to have special schools and classes for the education of the directive and superintending officials. Officials already in the service should be given courses to supplement their duties. It is especially necessary to take into account social and pedagogic training.
>
> "Candidates for penological service should demonstrate their aptitude for a practical and judicious accomplishment of their task; candidates for directive posts should demonstrate, among their qualifications, their aptitude for scientific treatment of problems involved in the execution of penalties, by an examination in theory and by practical service. Only those candidates should be definitely accepted who have proved, during a trial stage, that they possess, beside the necessary practical and scientific knowledge, a deep interest in their profession, a good character, love of their fellows, a knowledge of mankind, and an aptitude for treating abnormal persons from a psychological point of view.
>
> "Taking into account their respective functions, it is necessary to remunerate the different grades of officials sufficiently to assure them a decent economic position. . . ."

The opening sentence of this resolution may strike one as platitudinous. Yet it cannot be hammered home sufficiently that not everybody in any kind of job and with any kind of education and training is, or can be made to be, an expert in correctional work. For social self-protection alone, we shall within the next decade have to develop a definite movement toward the employment of trained and educated per-

sonnel in probation and parole work, in prison management, and in related fields. Social work in general is being more and more raised to the dignity of a skilled, as well as a very useful, profession; and the day will come when work with delinquents and criminals will be one of the most vigorous specialties of that profession. Already there is a beginning in Massachusetts, New York, and New Jersey, and in the Federal prison service. In Massachusetts there are a number of promising young men receiving theoretical and practical training in penal matters, and I hope that as we feel our way inductively, we can develop such training on a larger scale. The Federal authorities have established a school for prison officials. On the Continent they have long had excellent schools for training candidates for the police department. One such institution, in Vienna, offers a two-year course embracing such fields as sociology and psychology in addition to police subjects, instead of the one-month course in police regulations given in many American police departments.

As to the directive officials, they should, as the resolution provides, be men of higher education, scientific attitude, and humanitarian impulse. When more and more of our correctional officials are men who would be chosen as professors, deans, and presidents of colleges, the work will be raised to the dignity it deserves.

It is, therefore, a great pleasure to be able to record that the Institute of Criminal Law of the Harvard Law School is the first institution of the kind in America to have formulated and put into effect a program for training correctional administrators. Candidates will be carefully selected from among college graduates. They will be given a two-year course, not only in such obviously pertinent subjects as criminal law, criminal procedure and evidence, criminology, and penology, but in such studies as sociology and social pathology, psychology and psychopathology, education, government, social research, and similar fields. Thus all pertinent branches of learning will be focused on the great problem of crime, its causes, its treatment. It is our hope that graduates from this training course will approach their duties as executives and semi-executives of prisons, parole boards, probation systems, and so forth, adequately equipped in scientific train-

ing and humanitarian outlook to effect the proper balance in their work between society's aim of rehabilitating offenders and society's duty to maintain the general security. Students participating in the curriculum for correctional administrators will be given opportunities for gaining practical experience in the more progressive peno-correctional systems of the country. As a result of this practical demonstration, it will no longer be true to say that law schools and lawyers have paid little or no attention to the social-psychological implications of the crime problem, confining their interest in crime to that stepchild of the typical law-school curriculum—criminal law.

In providing for this training curriculum for correctional administrators, we do not, of course, overlook the leadership of a number of practical penologists who have risen from the ranks to make outstanding contributions to the treatment of crime. But such leadership and point of view are exceptional. When law schools were first proposed, men pointed to the fact that Abraham Lincoln never studied law in a law school. By and large, we cannot expect correctional work to become professionalized if we leave it to the haphazard chance of the able men in prison work rising to the top. The work of rehabilitation of offenders is of such unquestioned social importance that it deserves to be raised to the dignity of a skilled profession. The success of any enterprise with such an aim in mind, however, will depend upon the alertness and intelligence of the leaders in the various communities. If they demand a well-trained professionalized correctional administration, they can have it; if they insist upon overemphasis of politics in appointments to correctional posts, they have only themselves to blame for the results. It is believed, however, that intelligent public opinion is to-day so aroused that well-trained candidates will be more and more selected to man the important technical posts in the correctional field.

The above quoted resolution also stresses the need of improving *existing* correctional personnel through special training. A few winters ago the Massachusetts Department of Correction, under the leadership of Sanford Bates, made a beginning in this direction. It provided a series of lectures

on criminal law, the elements of psychiatry, penal management, and the like which penal administrators were invited to attend. The scheme was, of course, experimental; the lectures were few. But the experience must have widened the vision of penal officials somewhat and enriched their "mental climate". If such lectures could somehow be linked up with practical supervision of the kind provided in the better schools of social work, the standards of probation, parole, and prison administration would be materially raised.

There is, however, an important consideration in all this that is too often overlooked and that ought to be emphasized—that is, the need of consciously evolving a science as well as an art of criminology. There has, for example, been too little testing out of the possible value and necessary modification of social case-work, of various psychological, psychiatric, educational, and religious practices as applied to this field. After all, we know relatively little about the motivations and conditionings of the human animal and the functioning of the social organism. Let us be wary about claiming too much for mental hygiene, for psychiatry, for social work. Our chief justification, and the one we must rally around, is that these all represent a conscious attempt to be *thoughtful* in the handling of human maladjustments, instead of prejudiced and emotionally biased in angry resentment or superficial sentimentality. We need always to have a cautious check-up unit in our organizations for dealing with these problems, just as the modern industrial plant has its very important laboratory and research unit.

Perhaps the most determined stand taken by the American delegates was against solitary confinement—while at work, as well as at night. The question propounded to the delegates was:

> "In what measure and by what means is there place in the modern penitentiary system for the employment of a cellular régime side by side with life in association (*le régime en commun*)?"

Naturally, the American delegates looked with disfavor on a proposal that evidently had as its aim the rededication of penologists to the outworn ideals of the old "Pennsylvania System". The Americans insisted rather upon the extension of the dormitory system and the socialization of inmates that

is favored by life in association. A resolution to that effect was, however, voted down, and the following compromise adopted:

> "As a general rule, the system of separate confinement by night must be regarded as an essential part of modern prison treatment. But there may be exceptional circumstances in different countries which require a system of dormitories or rooms in common."

In addition, the following resolutions were voted:

> "1. The cellular system should be considered an organic part of any progressive system. At night, it is essential to modern administration.
>
> "2. As for prisoners on trial, the cellular system should be applied absolutely.
>
> "3. The cellular system by day for penalties of short duration has certain advantages and certain disadvantages. One can realize the advantages and avoid the disadvantages by adequate medical service and classification of the prisoners.
>
> "4. For long penalties the system of common cells by day can be used, provided the prisoners are never placed together while not working or being guarded. Surveillance can be relaxed in proportion to the separation of prisoners into homogeneous groups."

Prevention.—The first question of Section III, which dealt with prevention, was as follows:

> "How can the need of knowing the antecedents of certain persons (prisoners) be reconciled with the idea of rehabilitation and with efforts tending to facilitate the gaining of an honest living by the prisoner after his release?"

This question is rather awkardly phrased. In essence, it raises the difficulty that some local judges and parole officers have mentioned in answer to the question why probation and parole officers should not make more effort to trace down the employment history of offenders. In reply, it has been urged that this would jeopardize the latter's jobs. This is a practical difficulty, but one not insoluble. The following resolution was adopted on this question:

> "I. The end toward which the efforts of all should tend is a régime wherein release of the offender will be but a part of a precise method of amendment, and the activity of the liberated prisoner on parole be a continuation of his penitentiary treatment.
>
> "II. Under these conditions, it is necessary: (a) to influence public opinion, so that the public will become interested in the reform of released prisoners; (b) to separate the corrigible from the incorrigible, as, for example, by a test method applied by social-welfare agencies doing work with criminals (*sociétés de patronage*) and by recommending only

corrigible persons for release; (e) to individualize in choosing an occupation for the released prisoner, according to the character of the offense and social condition of the offender. . . ."

Unquestionably there is need of a program of education for the public, as well as for prisoners, regarding the real significance of such devices as probation and parole. Employers of labor, particularly, must be properly approached and asked to assume part of the responsibility for the rehabilitation of offenders. There is also great need of a more discriminating application of probation and parole to the individual case. It is necessary, also, to make offenders, complaining witnesses, lawyers, judges, and the public in general understand the true nature of probation and parole as not consisting essentially of a "lenient disposition", to which any particular prisoner is or is not "entitled", but of instruments in an armory for the scientific treatment of the offender. One of the reasons why parole and probation have not been as successful as they might be is just this fact that they have not been properly interpreted to offenders and their families, to complaining witnesses, to lawyers, to employers, and to the general public. Indeed, one prison riot was partly traceable to the inadequate interpretation of the indeterminate sentence and parole.

The next series of questions of Section III are too fundamental to have been decided upon mere *a priori* discussion at a congress. They require much intelligent research as a basis for reliable conclusions:

"What have been the results of the application of laws regarding probation and parole, from their introduction until the present time?

"What reforms must eventually be introduced in these institutions and in their functioning to render them more efficacious?

"What system could give the prisoner the assurance that if he satisfies the conditions prescribed by the regulations, he will be paroled after the minimum term fixed by the law?"

The resolutions were not in all respects clearly responsive to the questions:

"1. Suspended punishment (probation) and conditional liberty (parole) ought only be accorded to delinquents really suited to this system.

"2. Before granting probation or parole, the judge or the authority dealing with conditional liberation should procure and utilize detailed reports, made by officials of organizations and the authorities, on the physical, mental, or moral conditions of the delinquent.

"3. Social supervision (*le patronage*) is indispensable to the success of conditional liberation, and, as a rule, to obtaining good results in suspended punishment.

"4. States without a complete system of supervision by public officials should subsidize private welfare organizations engaged in this work, so that they may engage more salaried employees, and they should employ more officials to supervise the work of these associations.

"5. Scientific education of persons concerned in this work should be systematically organized either by private officials subsidized by the state or by the state itself.

"6. It is not desirable to guarantee the convict that, if he satisfies the regulatory conditions, he will be paroled in the minimum time fixed by the law. Nevertheless, the prisoner should be given the guaranty that the question of his conditional release will be gone into by an impartial authority in the minimum time fixed by the law. . . ."

Some of these resolutions are mere platitudes. *Of course* probation and parole ought to be granted only to persons suited to them. What effort has, however, been made to evolve a careful system, based on objectified experience, whereby judges and parole boards might with reasonable certainty be able to predict the future careers of various types of offender? Very little. We are only at the beginning of such a movement, and it is already meeting opposition on the strange and untenable ground that it threatens individualization. But a few informed students believe it to be the development necessary to give the individualizing process a sound foundation. The issue is complex and would require much discussion, but it resolves itself into the question, Is it better to individualize on the basis of that vague something called "the experience of the expert", or to reduce guesswork and compel the expert to objectify, and reflect upon, his experience? Put in that way, reasonable people should agree that the latter alternative is greatly to be preferred. Only a beginning toward this end has thus far been made, but it is of the utmost importance to encourage check-up studies of results of various forms of penal treatment applied to different types of offender, to see whether some rational policy of true individualization by judges and parole boards cannot be evolved inductively.

We would all subscribe, too, to the provision that thoroughgoing, illuminating case records, as objective and as accurate as possible, should be the basis of action by judges, parole boards, probation officers, and parole agents. So also would

we agree that supervision, in the sense of constructive social case-work, is indispensable if probation and parole are to be more than self-deceptive, meaningless motions.

The resolution regarding the undesirability of guaranteeing to the prisoner his release at a certain time if he conducts himself properly touches upon a very vexing problem in parole administration. Space is too limited to do more than reiterate the great need of properly interpreting the meaning of the indeterminate sentence and parole to the inmates. Printed regulations given the prisoners are not sufficient; basic attitudes toward parole will have to be changed before prisoners feel that their parole applications have been fairly disposed of. To the ordinary man in prison, justice means even-handed justice, not "scientific individualization", resulting sometimes in his having to serve longer than a prisoner who in his opinion committed a more serious offense. This attitude was not anticipated by the framers of indeterminate sentence and parole laws. It must be met more adequately than it has been in the past, if parole is to be successful.

It will be noticed that Section III seems to have sidestepped the important question as to the actual *results* of probation and parole. It is needless to reiterate that hunches and guesswork will never give us the answer; careful, unbiased research of a follow-up nature must be the order of the day, if we are to profit by our mistakes and improve our methods.

Youth.—To come now to the final section, on the problems of juvenile delinquents, space does not permit of treating all the matters discussed in its deliberations. The first question deals with the organization of children's courts. There will be so much said about this subject in the coming months by the various commissions engaged on the problem that I shall merely state the Prague resolution, to indicate its progressive nature:

> "The authority called upon to take cognizance of juvenile delinquency, whether exercised by judicial organs or not, ought in all cases be confided to persons qualified by their knowledge of children and inspired by the idea of protection, thus differing from that which deals with adult offenders.
>
> "The juvenile court should be composed as nearly as possible of a single judge, specialized in affairs of juvenile delinquency, or to permit the participation of assessors (referees), among whom the choice should

fall principally on physicians, teachers, and social workers. The collaboration of women either as judges or assessors is highly recommended.

"A detailed examination should be made of the antecedents, social background, and character of the child, with the view of enlightening the tribunal on the measures to apply; an examination in which recourse should be had, as much as possible, to the assistance of experts in psychiatry, education, and social work.

"Services auxiliary to the juvenile court should be confided to persons who have had special technical preparation and who devote themselves permanently to this task.

"The coöperation of volunteer workers is highly desirable; it always calls for direction and control by the professional element.

"These services should exercise a preventive and curative function embracing the period before, during, and after sentence.

"In order to facilitate the medical and physio-psychological examinations of juveniles, it is desirable to establish special observation centers, placed at the disposal of the juvenile court.

"Certain special establishments should likewise be organized to insure the execution of measures of treatment to which children are recognized as susceptible, the court keeping the control of the execution of the treatment and reserving the right to make any modification, suspension, or cessation, whether conditional or final."

Without going into a discussion of these various important features, it should be pointed out that in the last paragraph may lie the next step in the progress of treatment of juvenile delinquency. Juvenile courts at present, if one omits probation, have too little control over the treatment prescribed by them and carried out in various institutions. *No amount of good diagnostic work can take the place of the careful supervision of the treatment process.*

Lessons of the Congress.—What are the values of such a congress? In the first place, the opportunity of meeting eminent scholars and officials from other parts of the world is a source of great help in one's work and of pleasant social intercourse. Very important professional contacts are made; men and women whose works one has studied and puzzled over are met face to face. It is unfortunate that more time is not devoted, during a quinquennial congress, to the informal exchange of ideas in intimate conversation rather than formal debate.

Secondly, a congress such as this, while it cannot legislate, does affect public opinion in penal matters throughout the world. The resolutions take on considerable authority because of the standing of the delegates.

Thirdly, the congress gives some opportunity for workers

in various fields connected with correctional treatment, to test out their findings and ideas.

Fourthly, the congress acts as a sort of clearing house, enabling the delegates to learn what is going on in other sections of the world. In a way, it ministered to the Americans' good opinion of some of our home products in the correctional field. There was a source of pride in the contemplation that many of these weighty matters that *savants* were discussing had their origin and initial impetus in America: probation, parole, the indeterminate sentence, the juvenile clinic, the juvenile court, mental hygiene. It also made some of us realize what a grave responsibility rests upon American workers in this field to see that these ingenious devices are continually improved and to counteract the natural tendency toward automatism and mechanization. The chief lesson of this congress for me was that if America is to maintain the leadership so brilliantly begun by Dr. Wines, who initiated this great movement in international coöperation, it must not succumb to smug self-righteousness, but be continually alert to see that the content of penological practice is ever improved in scientific quality and ever refreshed by rededication to humanitarian ideals.

WHAT CONSTITUTES FELLOWSHIP TRAINING IN PSYCHIATRY: SOME FUNDAMENTALS

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ONE of the most vital questions that confront psychiatry to-day is that of providing adequately trained personnel. To help meet this demand in our field, fellowships have been granted by the Commonwealth Fund during the past decade. Many of these have been administered through The National Committee for Mental Hygiene and have furthered the successful Commonwealth Fund demonstrations in child-guidance work in seven of our larger cities.

During the past few years, the Commonwealth Fund has continued to stimulate and further the training of men in psychiatry by granting fellowships to several teaching institutions, including the Boston Psychopathic Hospital, the Henry Phipps Psychiatric Clinic, and the Colorado Psychopathic Hospital. The latter institution has elected to train men who have not had previous experience in psychiatry, but have completed one year's interneship or its equivalent after graduation. The Commonwealth Fund has been most liberal in providing for the local administration of these fellowships, and it has been possible through them to stimulate interest to the extent that we now expect that the majority of these fellowships will be filled by our own students.

Methods of training naturally vary in each teaching institution. The following report of our experiences up to date is an attempt to answer the question: What constitutes fellowship training in psychiatry?

Our fellowship training program began July 1, 1928, with three men chosen from a group of fourteen applicants. Each year since then we have chosen three men for a two-year fellowship period. These men have been selected on the following basis: A medical degree from a class-A medical

school, the completion of a general interneship or its equivalent in an approved hospital, and a personal interview to discover adaptability and general fitness for the field of psychiatry. Letters of recommendation from medical men and laymen personally acquainted with the applicant are also required. Attempts are made, too, to evaluate scholastic prerequisites such as undergraduate courses in sociology, psychology, and abnormal psychology. Most of our applicants appear to have received very little worth-while training in these subjects.

We have several reasons for selecting men who have just completed their interneship without any additional experience in the field. In the first place, we are anxious to attract our own students to take fellowships in psychiatry, and in the second place, we feel that men with previous psychiatric training might have preconceived ideas that would interfere with their progress. In the third place, it seems to us that the future of psychiatry is best served by stimulating young men to enter the field directly after completing their medical training and interneship. We also believe that it takes at least two years to complete many of the fundamentals of clinical psychiatry and that our active hospital service, out-patient service, and community-clinic service are well adapted for this training.

Following the two-year course of training in the fundamentals of clinical psychiatry, it is expected that our fellows will endeavor to obtain further training or experience—at least three additional years of it—whereby they can prepare to teach or to practice psychiatry, or some chosen specialty in the field. It is desirable that these men should satisfactorily pass examinations before an appropriate board of psychiatric examiners in order to enter the various fields of psychiatry—whether clinical, educational, or child-guidance work, industrial psychiatry, prison psychiatry, or other important branches.

The training given at the Colorado Psychopathic Hospital during the two-year fellowship in psychiatry is divided as follows: (1) survey of the fundamental literature in this field; (2) direct clinical contacts and responsibilities; (3) clinical contacts in the out-patient clinic; (4) clinical contacts in

the community clinics; (5) participation in clinical research; and (6) miscellaneous activities to broaden the point of view of each man and to further participation in a community program and in teaching.

1. *Reading.*—At the beginning of his fellowship, each man is presented with the following guide to reading in this field:

ASSIGNMENTS FOR THE COMMONWEALTH-FUND FELLOWS

It is expected that the following studies be completed during your term of fellowship. This schedule is to guide your reading, not to limit it.

General Reading:

Outlines of Psychiatry, by White (9th edition).
Textbook of Psychiatry, by Bleuler.
Textbook of Psychiatry, by Henderson and Gillespie (2nd edition).
Practical Clinical Psychiatry, by Strecker and Ebaugh (3rd edition).
Psychological Medicine, by Craig and Beaton.
Clinical Psychiatry, by Diefendorf.
The Psychology of Insanity, by Bernard Hart (4th edition).
Recent Advances in Psychiatry, by Devine.
Manual of Psychiatry, by Rosanoff.
Diagnosis of Nervous Diseases, by Purves-Stewart.
Elements of Scientific Psychology, by Dunlap.
The Principles of Psychology, by James.
The Emotions, by Lange.
Elements of Psychology, by Thorndike.
Educational Psychology, by Thorndike.
Psychotherapy, by Miller.
Introduction to Social Psychology, by McDougall.
An Outline of Abnormal Psychology, by Bridges.
Psychological Types or the Psychology of Individuation, by Jung.
Mind and Medicine, by Salmon.
Textbook of Clinical Neurology, by Wechsler.
Neuropathology, by Buzzard and Greenfield.
General Paresis, by Kraepelin.
Syphilis of the Nervous System, by Nonne.
Neurosyphilis, by Southard.
Recent Advances in Neurology, by Russell and Strauss.
Histopathologie des Nervensystems, by Spielmeyer.
Normale und pathologische Anatomie und Histologie des Grosshirns, by Jakob.
The Autonomic Functions and the Personality, by Kempf.
Physique and Character, by Kretschmer.
Diseases of the Nervous System, by Jelliffe and White (5th edition).
Shell-shock and Other Neuropsychiatric Problems, by Southard.
Diseases of the Nervous System, by Oppenheim (Volumes I and II).
Epilepsy, by Lennox and Cobb.
Benign Stupors, by Hoch.
Sleep and the Treatment of Its Disorders, by Gillespie.
Pathology and Histopathology of the Nervous System, by Schroeder.
Mental Disorder and the Criminal Law, by Glueck.

Five Hundred Criminal Carcers, by Glueck.
Guide for Psychiatric Examination, by Kirby.
Insanity and the Criminal Law, by White.
The Sympathetic Nervous System in Disease, by Brown.
Outlines of Examinations, by Adolf Meyer.
An Outline of Psychology, by Titchener.

Publications by the Association for Research in Nervous and Mental Diseases:

Vol. 1: *Acute Epidemic Encephalitis.*
Vol. 2: *Multiple Sclerosis.*
Vol. 3: *Heredity in Nervous and Mental Disease.*
Vol. 4: *The Human Cerebrospinal Fluid.*
Vol. 5: *Schizophrenia.*
Vol. 7: *The Cerebellum.*
Vol. 8: *The Intracranial Pressure in Health and Disease.*
Vol. 9: *The Vegetative Nervous System.*
Vol. 10: *Schizophrenia.*

Lecture Notes, prepared by Adolf Meyer.
Notes of Clinics, by Meyer and Kirby.
The Golden Bough, by Frazier.

These books are fundamental for our studies of clinical psychiatry.

It is expected that fellowship men will keep in touch with current literature, and the following journals constitute an irreducible minimum list:

English Journals:

Archives of Neurology and Psychiatry.
American Journal of Psychiatry.
Psychiatric Quarterly.
American Journal of Orthopsychiatry.
American Journal of Diseases of Children.
Child Development.
Child Study.
Mental Hygiene.
Journal of Nervous and Mental Disease.
Brain.
Journal of Neurology and Psychopathology.
Journal of Mental Science.
Psychoanalytic Review.
International Journal of Psycho-Analysis.
Journal of Abnormal and Social Psychology.
Archives of Internal Medicine.
Progressive Education.
Journal of Criminal Law.
Journal of Juvenile Research.

Foreign Journals:

Acta Psychiatrica et Neurologica.
Revue Neurologique.
Monatsschrift für Psychiatrie.
Zeitschrift für Die Gesamte Neurolgie und Psychiatrie.
Archiv für Psychiatrie und Nervenkrankheiten.
Der Nerven Artz.

Special assignments will be made after you have had six months' orientation and ward work and out-patient work in the hospital. Written and oral examinations will be given at the conclusion of each month as follows:

February: General Introduction.

Introductory chapters and careful review from the above textbooks, with special emphasis on:

Hart's *Psychology of Insanity.*
First five chapters of Henderson and Gillespie's *Textbook of Psychiatry.*
First twelve chapters of Bleuler's *Textbook of Psychiatry.*
First four chapters of White's *Outlines of Psychiatry.*
First three chapters of Strecker and Ebaugh's *Practical Clinical Psychiatry.*
Outlines for Examination, by Adolf Meyer.

March: Organic Reaction Types (Anergasias).

This assignment covers the sections in all the above textbooks, with emphasis on the *Lecture Notes* by Adolf Meyer and special reprints assigned. It is expected that fellows will review very carefully Gerstmann's *Die Malaria Behandlung Der Progressiven Paralyse.*

April: The Delirious and Hallucinatory Reactions (Dysergasias).

Routine reading of chapters and sections in the above textbooks.
Lecture Notes, by Adolf Meyer.
Special reprints and articles as assigned in conferences.

May: Paranoic Reaction Types (Paraergasias).

Sections from the above textbooks.
Manic-Depressive Insanity and Paranoia, by Kraepelin.
Special reprints and articles as assigned in conferences.
Notes on Paraergastic Reactions, by Adolf Meyer.

June: Affective Reaction Types (Thymergasias).

Sections from the above textbooks.
Manic-Depressive Insanity and Paranoia, by Kraepelin.
The Thymergastic or Affective Reaction Sets, by Adolf Meyer.
Special articles as assigned in ward conferences.

July: The Schizophrenic Reaction Types (Paraergasias).

In addition to the sections of the above textbooks on this topic all of the early reprints by Adolf Meyer are assigned.
The Paraergastic Reactions, by Adolf Meyer.
Dementia Praecox and Paraphrenia, by Kraepelin.
The Treatment of Schizophrenia, by Hinsie.
A complete review is to be made of the monograph published by the Association for Research in Nervous and Mental Diseases on schizophrenia.

December: The Psychoneurotic Reaction Types (Merergastic Reactions).

Sections from the above textbooks and special assignments as given in ward conferences.
The Neurotic Personality, by R. G. Gordon.
Principles of Psychotherapy, by Janet.
Typewritten Lectures, by Adolf Meyer.
Hysteria, by Kretschmer.

January: Mental Deficiency (Oligergastic) and Constitutional Psychopathic Inferiority.

Sections from the above textbooks.

Notes by Adolf Meyer.

Mental Deficiency, by Tredgold.

Special reprints centering around Dr. Fernald's state program as assigned in ward conferences.

February: Child-Guidance Problems and Preventive Psychiatry.

Fundamental books which you have previously studied in your work are:

Everyday Problems of the Everyday Child, by Thom.
Child Guidance, by Blanton.
Intelligent Parenthood, Chicago Association for Child Study and Parent Education.
Parents on Probation, by Miriam Van Waters.
Difficulties in Child Development, by Chadwick.
The Adolescent Girl, by Blanchard.
The Nervous Child, by Cameron.
The Problem Child in School, by Sayles.
Fifty-five Bad Boys, by Hartwell.
The Problem Child in the Home, by Sayles.
Three Problem Children, by Sayles.
Personality Adjustment of School Children, by Zachry.
Teachers' Attitudes and Children's Behavior, by Wickham.
Mental Hygiene and Social Service, by Kenworthy and Lee.
Parents and the Pre-school Child, by Blatz and Bott.
The Management of Young Children, by Blatz and Bott.
Adolescence, by Frankwood Williams.
The Normal Mind, by Burnham.
Stammering, by Appelt.
Correcting Speech Defects, by McCullough.
Social Control of the Mentally Deficient, by Davies.
Psychoanalysis in the Classroom, by Green.
The Unstable Child, by Mateer.
Mental Deficiency, by Tredgold.

March and April: Psychoanalytic Concepts.

An Introduction to Psychoanalysis, by Brill.
General Introduction to Psychoanalysis, by Freud.
Three Contributions to the Theory of Sex, by Freud.
Group Psychology and the Analysis of the Ego, by Freud.
Selected Papers on Hysteria and Other Psychoneuroses, by Freud.
Psychoanalysis of the Total Personality, by Alexander.
Psychopathology of Everyday Life, by Freud.
Interpretation of Dreams, by Freud.
Critical Examination of Psychoanalysis, by Wohlgemuth.
Psychology of the Unconscious, by Jung.
Analytical Psychology, by Jung.
Psychopathology, by Kempf.
Morbid Fears and Compulsions, by Frink.
The Psychoanalytic Method, by Pfister.
Papers on Psychoanalysis, by Jones.
Treatment of the Neuroses, by Jones.

Practice and Theory of Individual Psychology, by Adler.
The Neurotic Constitution, by Adler.
Dissociation of a Personality, by Prince.
The Criminal, The Judge, and the Public, by Alexander and Staub.
Introduction to a Psychoanalytic Psychiatry, by Schilder.
Unconscious Mind, by Schofield.
Peculiarities of Behavior, by Stekel.
Outline of Psychoanalysis, by Van Teslaar.
Treatment of the Neuroses, by Jones.
War Neuroses, by MacCurdy.
The Common Neuroses, by Ross.
Traitment des Psychoneuroses de Guerre, by Roussy.
The New Psychology and the Teacher, by Miller.
The Psychology of Daydreams, by Varendonck.
Mental Conflicts and Misconduct, by Healy.
The Individual Delinquent, by Healy.
History and Practice of Psychoanalysis, by Bjerre.

Due to their wide use by the general public, fellows should be familiar with the following books:

A Mind that Found Itself, by Beers.
Discovering Ourselves, by Strecker and Appel.
Just Nerves, by Riggs.
Outwitting Our Nerves, by Jackson and Salisbury.
Intelligent Living, by Riggs.
Gestalt Psychology, by Kohler.
Personality, by Gordon.
Reluctantly Told, by Hillyer.
The Human Mind, by Menninger.
Re-creating the Individual, by Hinkle.
Mental Adjustments, by Wells.
Signs of Sanity and the Principles of Mental Hygiene, by Paton.

This guide was prepared to stimulate the student's interest in psychiatry as well as to insure knowledge of the main developments in our field up to the present time. Each fellow is given a period of six months to cover this preliminary reading. A series of written examinations is then given covering the following subjects: the organic reaction types, delirious and hallucinatory reaction types, paranoid reaction types, affective reaction types, psychoneurotic reaction types, schizophrenic reaction types, mental deficiency and affective deficiency, mental hygiene and child guidance, psychoanalytical literature and concepts. This guide for reading is, of course, not sharply demarcated and from time to time additions are made to the above list. For explanatory purposes I am inclosing one or two sets of the examination questions given the fellows on these subjects.

ORGANIC REACTION TYPES

Examination for Junior Fellows, March, 1931

1. (a) Outline the main facts of the organic reaction types.
   (b) Outline the early symptoms of general paresis.
   (c) State Nonne's views regarding the invasion of the brain and the development of cerebral syphilis.
2. (a) Outline the early symptoms of senile deterioration, stating your opinion regarding the cases that should be certified. What methods can be further utilized to prevent certification of many of these individuals?
   (b) Give the present-day concepts regarding the convulsive states and outline methods of treatment, giving the principles upon which each depends.
3. (a) Classify the traumatic psychoses, giving the differential psychiatric features of each group, neurological findings, encephalographic findings, and laboratory findings.
   (b) Outline the mental symptoms to be expected in frontal tumors.

PSYCHONEUROSES

Examination for Senior Fellows, December, 1930

1. Discuss the various contributions established concerning the psychoneuroses by: (1) Charcot, (2) Babinski, (3) Freud, (4) Janet, (5) Beard, (6) Jung, (7) Adler.
2. (a) Classify the psychoneuroses.
   (b) Discuss the psychopathology of anxiety states, indicating very clearly the physical and mental phenomena.
3. Outline in detail your treatment of the psychoneuroses, indicating the dangers of a positive transference.

2. *Ward Work.*—We feel very strongly that the present-day emphasis on education through the "learning-by-doing method" is very appropriate and essential for training in psychiatry. On this basis it has been our policy to consider each fellow as a resident house officer in the hospital. He serves as an integral part of the hospital staff, assuming ward responsibilities for each patient assigned to him, under the close supervision of a senior psychiatrist. In our clinic one senior is responsible for the instruction and training of two fellows. This ratio of one senior instructor to two fellows is an irreducible minimum. Each fellow is held responsible for the individual examinations made on each patient. This includes, of course, the taking of a complete history, with the essential supplementary social studies; the completion of the physical studies; laboratory and special investigations in each case; the completion of psychiatric examinations; the preparation of progress reports after staff conferences on

each case; and contacts with relatives, physicians, nurses, social-service workers, occupational therapists, and all of those concerned with the proper treatment of the patient. In addition to the staff ward conferences, each fellow has close contact with the senior psychiatrist, and one period each week is set aside for individual discussion of ward problems current. In addition, the fellows should have close contact with the work of the clinical psychologist. Opportunities are provided for special clinical procedures, such as cisternal puncture, encephalography, and other indicated studies. Definite knowledge of neuropathological laboratory investigations and methods utilized in the study of urine, blood, and spinal fluid are, of course, essential for fellowship training. In this clinic we utilize for the routine study of mental disorders the schemes devised by Adolf Meyer, which we feel are the most satisfactory. The biological point of view through genetic dynamic concepts is utilized for the individual cases studied. We have found the study of mental disorders by graphic methods very stimulating. These graphic charts, which have been referred to in a previous paper,[1] are given on pages 800 and 801. In the course of a year each fellow should make a complete study of approximately 100 treatment cases. This means an average admission rate of about two patients per man per week. Since approximately 20 per cent of our admissions are organic cases, ample time is left for the study of our functional cases. The average total number of cases under treatment in the hospital ranges from 10 to 12 for each man, as our daily average hospital census is 72 patients.

3. *Out-Patient Work.*—Throughout the whole training period, extra-hospital developments are emphasized. In fact, in the preliminary discussions with fellows, we emphasize very clearly the present-day trend in psychiatry as being away from the hospital back into the community where mental disorders originate. Our out-patient facilities, which are most active, consist of the following divisions: (1) a clinic for follow-up care of all cases of general paresis receiving specific or non-specific treatment in the hospital; (2) a follow-up clinic

[1] "Some Present-Day Trends in the Teaching of Psychiatry," by Franklin G. Ebaugh. Presidential Address, Central Neuropsychiatric Association, Chicago, September 26, 1930; published in *The Journal of Nervous and Mental Disease*, Vol. 73, pp. 384–94, April, 1931.

Cross-section Approach to the Study of Mental Disorder

(Ebaugh)

In this clinic the following formula represents the classification used. There are seven main reaction types to be studied and differentiated. The type of individual make-up and the type of situation he is called upon to meet must be considered, the result of this equation being the reaction of the situation.

INDIVIDUAL	plus	SITUATION	leads to	REACTION
(What patient has to react with)		(What patient has to react to)		Adjustment. Normal behavior. Maladjustment—resulting in:
A. Physical: 1. Body type. 2. Features. 3. Physical defects. 4. General health.		*A. Toxic factors:* 1. Focal diseases and infections. 2. Drugs. 3. Alcohol.		*A. Seven main types of psychoses:* 1. Organic reaction type a. General paresis. b. Senile deterioration. c. Cerebral arteriosclerosis. d. Traumatic psychosis. e. Epilepsy, etc. 2. Delirious and hallucinatory reaction types (toxic psychoses) a. Alcoholic psychoses. b. Psychoses due to drugs and other exogenous toxins. c. Psychoses with somatic disease. 3. Paranoid reaction types. 4. Affective reaction types (manic-depressive or reactive). a. Depression. b. Excitement. c. Anxiety. 5. Psychoneurotic reaction types. a. Hysteria. b. Psychasthenia. c. Anxiety neurosis. d. Hypochondriasis. e. Chronic invalidism. f. Other types. 6. Primary constitutional reaction type a. Psychopathic inferior. b. Mental deficiency. 7. Schizophrenic reaction types (dementia praecox).
B. Intellect: 1. General level. 2. Intelligence quotient.		*B. Organic factors:* Definite brain changes to explain mental disorders; syphilis and various degenerative neurological conditions, epilepsy, cerebral trauma, etc.		
C. Habits: 1. Capacity for habit formation. 2. Personal and social habits. 3. Industrial habits. 4. Drugs, etc.		*C. Psychogenic factors:* External: Environmental factors—home surroundings, financial loss, worry, economic stress and strain, etc. Internal: Disturbances of inner mental life; repressions, conflicts, reaction to broken engagements, sex episodes, etc.		
D. Instincts: 1. Self-preservation. 2. Race-preservation. 3. Herd.				
E. Emotions: 1. General emotional tone. 2. Drive. 3. Stability.				
		D. Recommendations		*B. Results:* After treatment—1st year, 2nd year, 3rd year, 4th year, 5th year.

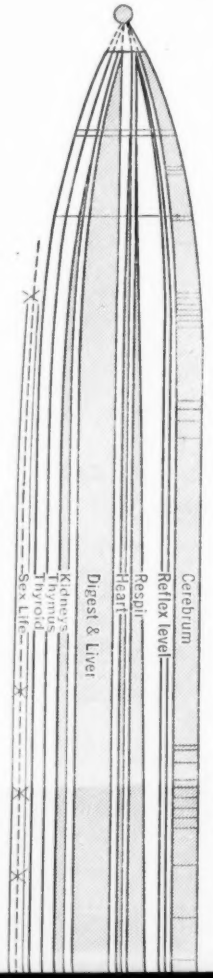
After treatment—1st year, 2nd year, 3rd year, 4th year, 5th year.

LONGITUDINAL GRAPHIC METHOD OF CASE STUDY
(ADOLF MEYER)

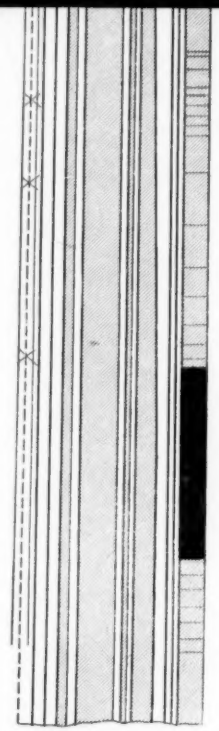
CASE NUMBER: R. B. No. 2489. White. Male. Age 23. Clerk. Protestant. Psychasthenic Reaction Type.
HEREDITY: Domineering Father. Over-Solicitous Mother. Patient Is Only Son.

YEAR: | BIRTHDAY: May 20th.

YEAR				Age
1906		Birth normal.		
1907		Dentition, walking, and talking.	Patient and family live in Denver.	1
1908				2
1909	Measles. Whooping cough.			3
1910		Night terrors		4
1911	Tonsillectomy.	Over-tidy.		5
1912			Entered grade school.	6
1913	Masturbation-continued to present time.	Began masturbating. Always alone and never with other boys. Told by father it would ruin his body and make him insane. Threat of castration.		7
1914	Disturbed sleep.	Began to have disturbed sleep. Would jump up at night and play ball in his sleep.		8
1915		Over-interest in athletics and much preoccupied with ideals of physical health. Conflicts well compensated by athletic outlets and interests in school.		9
1916				10
1917		Played on baseball, basket ball, and football teams. A good athlete.		11
1918				12
1919	Puberty. Masturbation continued with emissions.	Excellent scholarship.		13
1920		Beginning tension over sex life.	Entered high school.	14
1921	Tension states. Homosexual episode.	Seduction of a younger boy by patient. Mutual masturbation with boy friend. Periods of preoccupation.		15
1922	Homosexual episode. Anxiety.			16
1923		Unable to emancipate from home. Good scholarship.		17
			Entered college.	18



	continued with emissions.			
1920		Beginning tension over sex life.	Entered high school.	14
1921	Tension states. Homosexual episode.	Seduction of a younger boy by patient. Mutual masturbation with boy friend. Periods of preoccupation.		15
1922	Homosexual episode. Anxiety.			16
1923		Unable to emancipate from home. Good scholarship.		17
1924	Detached semilunar cartilage.	Forced to cease athletic outlets. Increase in masturbation with increased conflicts.	Entered college.	18
1925	Heterosexual contacts. Panic.	Attempts to overcome masturbation by promiscuity with harlots. Sudden panic while in barber shop.		19
1926		Failing scholarship. Sudden panic while in street car.		20
1927	Compulsions. Projections.	Treated by physician who prescribed travel. Marked inferiority feelings and ideas that people could tell he masturbated. Fear of insanity, sterility, or death.	Left college. Pleasure trip.	21
1928	Fully developed psychasthenia, with fear of crowds, street cars, walking alone, etc.	In hospital one month. Markedly improved. Separated from home. Working.	Employment. Colorado Psychopathic Hospital.	22
1929		Fear reactions under control and are tolerated.	Boarding and working.	23



This figure represents the development and integration of the various systems of the body, beginning at birth. Organic growth is indicated by the increased width of the column in ratio to the organ weight at that age. Data on medical, surgical, and psychiatric diseases and facts of the sex life are indicated on the left side of the column, and on the right side, general reactions of the patient to the various changes noted in the other columns. Trend reactions that seem important are underlined. Breaks in integration are noted by shading in the diagram to indicate extent, duration, and the integration level involved.

CASE HISTORY ILLUSTRATING CROSS-SECTION APPROACH

[illegible] White male, aged twenty-four, single, farmer, Mennonite. Schizophrenia, hebephrenic type.

CASE HISTORY ILLUSTRATING CROSS-SECTION APPROACH

Case 49. No. 2206. White, male, aged twenty-four, single, farmer, Mennonite. Schizophrenia, hebephrenic type.

Main facts.—Admitted to the hospital June 15, 1928, with complaint of odd behavior. He had been picked up on the road, a few days before admission, in the act of removing his clothing. He clutched at his abdomen and claimed that he was fighting with the devil. One month before this incident, his back had been injured in an accident. Six years previously, he had been a patient in a private sanitarium for nine months, during which time he had "communicated with God" and read the Bible a great deal. He had been an ordinary farm lad, more or less introverted, in a family of the Mennonite faith and markedly over-religious. Two years before his first illness, he had been baptized. From this time on there had been a more or less serious conflict regarding his sex life and his religious interests. The present attack had been ushered in by an episode that occurred while the patient was out in an automobile with his sweetheart. After intercourse he saw the moon "as if it had two searchlights on it". He took this to be a sign from God and gradually developed his other ideas.

INDIVIDUAL MAKE-UP

A. Physical:
1. Body type: Athletic.
2. Features: Regular, angular.
3. General health: Very good.
4. Defects: None.

B. Intellect:
1. General level: Average adult.

C. Habits:
1. Capacity for habit formation: Capable of adjusting to new routine.
2. Personal habits: Neat, clean, tidy.
3. Social habits: Few social outlets other than church contacts.
4. Industrial habits: No consistent employment history.
5. Habit pattern of response: Tendency to withdraw from conflicts with formation of phantasies.

D. Instincts:
1. Self-preservation: Normally concerned regarding health and survival.
2. Race-preservation: Normal interest in sex and marriage.
3. Herd: Liked company and social outlets.

E. Emotions:
1. General emotional tone: Happy, pleasant, contented, optimistic.
2. Drive: Ambitious beyond his ability. Efforts not well directed or controlled.
3. Stability: Variable.
4. Dissociation: Slight tendency to ambivalence.

F. Heredity:
1. Family overly interested in religion.

SITUATION

A. Toxic factors: None.

B. Organic factors: None.

C. Psychogenic factors:
1. Closely supervised at home.
2. Overly religious.
3. Very few girl friends.
4. Inadequate outlets.
5. Masturbatory conflict.
6. Conflict over sexual intercourse.
7. Conflict over breaking of engagement by sweetheart.

REACTION

1. Peculiar behavior:
   a. Tearing off clothing.
   b. Clutching abdomen.
2. Over-religious tendencies.
3. Visual hallucinations.
4. Auditory hallucinations:
   a. God has willed him to do certain things.
5. Grimacing and silliness.
6. Believed sweetheart had been given to him by God.

RECOMMENDATIONS

1. Institutionalization with activity, hydrotherapy, and supervision during acute illness.
2. Discussion, desensitization, and reëducation regarding conflict material.
3. Formulation of adequate social, industrial, and recreational program on leaving hospital.
4. Separation from family.
5. Prolonged follow-up supervision in out-patient department.

Markedly improved with good insight after three months' intensive psychotherapy in the hospital.

Two years later, making a good social and industrial adjustment.

of patients previously treated in the hospital; (3) a child-guidance clinic.

In the paretic clinic, the fellow has an opportunity to check up clinical examinations and opinions given during hospital care; to conduct the usual treatment procedures, consisting of intravenous tryparsamide and other arsenicals; and to check carefully laboratory studies in the attempt to correlate the clinical progress of each patient with serological and encephalographic studies. In this clinic especially, the fellow sees the importance of careful follow-up and of establishing close contacts with social-service workers. Despite many difficulties, approximately 90 per cent of those receiving treatment in the hospital in this group are followed. Here the fellow has many close contacts with practicing physicians who have expressed marked interest in post-malaria paretics. He also has the opportunity of seeing abundant clinical material freely utilized in teaching medical students.

The follow-up clinic handles a large number of functional cases treated in the hospital, especially cases representative of the psychoneurotic and schizophrenic reaction types. In many of these cases the therapeutic leads established in the hospital are carried on in order to establish a continued adjustment in the community. In this clinic the fellow has an opportunity to show his maturity in making decisions about ambulant types in regard to the advisability of hospital care or continued out-patient care. Under close supervision, each fellow is stimulated to make these decisions directly to the senior psychiatrist.

The child-guidance clinic represents the largest clinic service given and the greater part of the training in the out-patient clinic is taken up by this activity. The clinic set-up is the approved one, consisting of psychiatrists, psychologist, and psychiatric social workers. All cases are discussed at staff conferences at regular intervals in this clinic, after the completion of the fourfold type of examinations (social, psychiatric, physical, and psychometric) so well emphasized and formulated by leaders in child guidance. The main emphasis of our training has been placed on a study of the behavior and personality problems of childhood. Here the fellow has an opportunity to study mental mechanisms in the making.

This leads to a change in therapeutic point of view and to an understanding of mental conflicts as related to the later development of psychoses and neuroses. We feel that it is undesirable to separate child-guidance training from ward work, in which the fellow gains perspective concerning the early and intermediate development of mental disorders, as well as the later stages.

4. *Community-Clinic Service.*—A university psychopathic hospital should develop abundant contacts throughout the entire state. It was the former policy of this hospital to take part in mobile clinics established by the Colorado Child Welfare Bureau and the Extension Department of the University. This was abandoned owing to the incompleteness of the studies made and the poor quality of the work accomplished in an unsuccessful attempt to study large numbers of cases in a limited time. Our participation, however, in these mobile clinics was a valuable one for us in that it led to an accumulation of knowledge of various communities in the state. For instance, during the two-year period 1925–1927, over 100 communities were visited and served by this clinic, and approximately 10 per cent of all the children examined by the pediatricians were referred for psychiatric examination. When the mobile clinics were discontinued, there was a demand for mental-hygiene service from several communities, centering around the county medical societies, and the social and health organizations, and as a result the so-called community base clinics were organized. At the present time we have five such clinic centers in the state. I feel their main value is in the educational rather than in the clinical field. Close contacts are established with the schools, public-health nurses, physicians, and courts in these communities. A fellow participates in these clinics with a senior psychiatrist. The fellow, therefore, has an opportunity to take part in community programs and conferences held routinely with the medical group or with the nursing and school group. Many of the problems encountered in these clinics are of interest, and satisfactory adjustments are established, as is illustrated by the following case abstract prepared by one of our fellows, Dr. Charles A. Rymer:

Greeley Clinic, No. 487. E. C., a white boy of fifteen. Second oldest in family of four. Average intelligence; I.Q. 99. At present is a sophomore in high school.

Problem as referred: Considered as a behavior problem because of the situation existing between himself and his stepfather. The stepfather had many complaints, such as patient's attempted intercourse with his daughter (patient's half-sister) and failure to get along with the stepfather, which included an antagonistic attitude toward him and an unwillingness to coöperate in the home. The stepfather had written to both school-teacher and assistant district attorney, advising that patient be persecuted for his sex act. Enuresis was considered a problem from a health standpoint.

Evolution of problem: Ten years ago (July 10, 1920) mother of patient remarried, following the death of her husband (October 10, 1916). There had been two children by the first marriage, the patient being the younger of two boys. The stepfather has never gotten along well with either boy, especially the youngest. His treatment has been very inhumane; he has beaten both boys a great deal and because of this the older boy left home two years ago. The stepfather wanted children of his own and when his first child died at the age of six months, he became very despondent and his treatment of his two stepsons became more unbearable. However, his attitude has changed little following the birth of his two living children. He has objected to his stepsons' participation in athletics in school and has not allowed any play about the home. Work is the only activity allowed. The patient has to sneak away from home in order to play and on returning usually has to stand a good thrashing. The father is desirous that the patient finish high school and then go to college in order that he may become a "big business man". On many occasions he has refused to allow either boy to go to school parties and entertainments. Occasionally the patient has been allowed to go to parties, and when this has happened, his enuresis has disappeared. This has produced rejoicing on the boy's part. At other times the patient becomes very nervous and uncertain about things and bed-wetting presents itself, much to the boy's chagrin.

Four months prior to the clinic visit, the patient attempted intercourse with his half-sister, five years old. When the father found out about this, he became very angry and, while attempting to control his temper, criticized the boy severely. There had been no previous sex instruction and now the stepfather attempted to make a brief explanation, but under his emotional strain did a poor job of it. The boy was taken to a general practitioner—one not in good standing with the medical society—who also attempted to tell him something of sex. In this talk he was told that if he continued masturbation, which he had freely admitted, he would in all probability develop a mental disorder.

The stepfather is a hard-working, economical Scotchman, owner of 162 acres of farm land in a very prosperous community. He never had a chance at education and now wants to give his two stepchildren and his own two children all the benefits denied him. In return he expects absolute obedience from all, and when this is not forthcoming, loses his temper and beats the children. His wife has been instructed to keep her hands off and has been threatened with the same type of treatment. The father has patterned his action after that of his own father who was

very strict and had a very violent temper. The paternal grandmother states that all four of her boys practiced self-abuse and quarreled a great deal. The paternal grandfather drank and had a temper. The patient was born in their home and lived there for five years, until the death of his father.

The mother's health was good during pregnancy. Delivery was normal. Baby was breast fed. Teeth at six months. Child walked at one year and talked at one year. Sphincter control was established at eleven months. Health has always been good, with the exception of the usual childhood diseases. May, 1930, was noted to be seven and one-half pounds underweight.

Physical examination: Essentially negative.

Psychiatric examination: The patient's attitude was considered good during the interview, as he entered very well into the spirit of the examination. He was very willing to talk over his troubles. He appeared surprised when no great importance was placed on his statement, "You know I raped my sister and that is the reason I am here. A doctor told me I might go insane. I have worried a great deal over this. It has caused me trouble in school. I daydream a great deal, thinking about things that might happen to me."

He felt that he was the equal of others at school, but at home he really felt very inferior because of the things his stepfather said to him, telling him that he was no good and criticizing every action. He had begun to feel that maybe he wasn't any good. At school he did take part in activities and loved to clown for the younger children. He is liked by all the children at school, even though he is considered by some a bit shy and self-conscious. He gets along with children of his own age. He feels that the main trouble at the present time is between his father and himself, and that the father is greatly at fault. At school he has made a good adjustment with pupils and teachers. Teacher says he is a bit slow at times and hard to draw out of his dreams.

He feels that he must stay in the family to protect his mother, but has told her that if he was making it harder for her, he would leave home. He gets along very well with all members of the family save his stepfather.

He has been greatly concerned over the episode with his half-sister. In his daydreams he has pictured himself away from home, where things might be a good deal more congenial and happier. He has wanted to take his mother with him. There is no history of any night dreams. He desires to finish high school and go to college, perhaps to agricultural college.

Formulation: We are here dealing with an adolescent boy who is attempting to make his adjustment to life in face of a great deal of difficulty in the home. Marked abuse on the part of the father has made the boy feel very antagonistic and inferior. The relationship between the boy and the problems presented by the father's attitude can readily be understood.

It was felt that this case represented a very important problem which centered around the stepfather and his attitude. As the stepfather had received little education, his one desire in life was to give his children the things he had missed. In his attempt to accomplish this, he had stressed school work to the exclusion of all other interests. He became

very resentful whenever the boys had any other desires and objected bitterly to their attempts to fulfill their own wishes. Gradually he had become more rigid in his attitude toward the children and felt that they were not appreciative of his efforts. On this basis he had become critical and abusive in his relationship with them. The oldest boy refused to tolerate such an attitude and emancipated himself by leaving home, while the patient felt that he could not do this because of his feeling of responsibility for his mother. The father accepted our explanation of the difficulty, and was very coöperative in further psychiatric interviews, which resulted in the development of insight into the problem.

The main recommendation made in regard to the patient was that he leave home and secure work for room and board while continuing school. This was easily accomplished. Further treatment recommended dealt with explanations of sex phenomena to the patient and attempts to desensitize him to his feelings of insecurity and inferiority. This gradually resulted in improvement in proportion to the change in attitude assumed toward the boy and his problem. Follow-up reports one year later indicate continued adjustment.

The above training program has been gradually extended, depending on the interest and initiative and the grasping of clinical opportunities by each physician. This is especially true in the out-patient and community clinics. During the first year, the second-year fellow acts as a senior and the first-year fellow as a junior in the out-patient clinic. During the fellowship training, each man has an opportunity to attend approximately fifteen community clinics. The estimated total clinic days in the community is forty-two, and the clinic sessions per year in the hospital occupy 208 mornings.

5. *Research.*—We feel that it is very advisable for fellows to be encouraged in clinical research during their period of training, especially during their second year. The choice of topics should be voluntary and each man should follow through his own interests. The preparation of clinical case reports on all occasions is encouraged and considerable interesting unpublished clinical material has been developed. The following articles have been published by our fellowship group up to date:

"Herpes Ophthalmicus Febrilis with Dendritic Keratitis and Complicating Therapeutic Malaria," by Franklin G. Ebaugh, M.D., and Roland A. Jefferson, M.D. *Archives of Neurology and Psychiatry*, Vol. 22, pp. 1226–32, December, 1929.

"Comment on the Mechanism of Narcolepsy with Case Reports," by Carl P. Wagner, M.D. *Journal of Nervous and Mental Disease*, Vol. 72, pp. 405–16, October, 1930.

"Incidence of Bromide Intoxication among Psychiatric Patients," by

Carl P. Wagner, M.D., and D. Elizabeth Bunbury, M.D. *Journal of American Medical Association*, Vol. 95, pp. 1725–28, December 6, 1930.

"Medical Aspects of Malaria Therapy in Neurosyphilis," by George S. Johnson, M.D., and Roland A. Jefferson, M.D. *Journal of Nervous and Mental Disease*, Vol. 73, pp. 405–14, April, 1931.

"Encephalographic Studies in General Paresis," by Franklin G. Ebaugh, M.D., Hugh E. Kiene, M.D., Henry H. Dixon, M.D., and Kenneth D. Allen, M.D. *American Journal of Psychiatry*, Vol. 10, pp. 737–60, March, 1931.

In addition the fellows have all contributed to hospital bulletins prepared for the general practitioners of the state:

Bulletin No. 1—*The Treatment of Neurosyphilis*, January, 1930.
Bulletin No. 2—*Psychoneuroses*, April, 1930.
Bulletin No. 3—*Toxic Psychoses (Exogenous Group—Drugs)*, August, 1930.
Bulletin No. 4—*Child-Guidance Problems in Colorado*, March, 1931.

At the present time there are several additional topics awaiting completion and publication. One of these, *The Treatment of Muscle Rigidity and Tremor Due to Pallidal Disease by Sodium Fluoride*, is of considerable interest in that it represents the attempt of the physician, Dr. Henry H. Dixon, to follow through many research leads established when he was a National Research fellow at the Institute of Neurology under Dr. S. W. Ranson.

Our nine fellows have taken an active part in the case studies conducted at the state home for boys and the state home for girls. One of these studies has been published by the university, and represents factual reports on the delinquency situation in Colorado. Numerous miscellaneous topics have been covered, as well as many clinical-pathological reports from the abundant case material present. The most important consideration in connection with research will of course depend on the preparation of these men in fundamental methods of study and investigation and in reporting accurately their observations.

6. *Miscellaneous.*—There are numerous additional possibilities for training during the two-year fellowship, such as attendance at the regular lectures and demonstrations given for students. Each fellow serves as an assistant in the department of psychiatry. During his second year, he takes part in section teaching. Each man takes care of a small group of medical students, and case presentations are made to the

students from material in the hospital as well as the out-patient clinic. At regular intervals journal clubs are held where each fellow joins in active discussions regarding current literature, book reviews, and changing points of view in our clinic based on results of treatment.

Colorado has a law whereby criminals who make a plea of insanity are sent to the hospital for study. During the past three years our fellows have had opportunity to study 100 such cases. This has led to a better understanding of the phenomena of crime and has stimulated interest in this important psychiatric problem.

Free contacts are established with distinguished visitors to the clinic each year, and many other stimulating contacts are furthered with representatives from other fields of medicine through monthly attendance at faculty clinics and special clinics in the adjoining general hospital.

Perhaps the most stimulating contacts established by our fellows are with the heads of other departments in the medical school and the chiefs of the clinical services in the adjoining general hospital through participation in an active and satisfactory consultation service. Our fellows are thus kept in constant touch with developments in other fields of medicine. Many cases are studied by representatives of two or more departments. In fact, only through the closest contacts with other fields of medicine can the psychiatrist study the total individual. Combined and liaison teaching is beginning to develop. The department of gynecology and obstetrics offers many facilities for meeting this essential need of breaking down the isolation of psychiatric teaching. Each fellow is taught that psychiatry should merge with the other fields of medicine. At the present time three of our fellows are conducting studies in the department of medicine in the medical wards and out-patient clinic, as well as in the departments of surgery, gynecology, and obstetrics.

The following is an illustrative case report recently made by one of our fellows, Dr. Roland A. Jefferson.

Case 15. J. P. H. A white male, forty years of age, single and unemployed. Formerly a railroad employee. Consultation report following request for psychiatric consultation from medical out-patient clinic of Colorado General Hospital.

Problem as referred: Extreme restlessness, cold hands and feet, constipation, and throbbing sensation in abdomen—"it went right down and got into my genitals". The patient states that he feels panicky.

Onset and development: The present condition came on suddenly after edentulation (in three sittings). The patient entered the medical clinic of the Colorado General Hospital in February, 1931, complaining of toothache, decayed teeth, and so forth. He had been to a dentist previously, in the summer of 1930, and was at that time advised to have the teeth extracted. He became very much agitated and decided to try his own methods to save them. During the fall and winter months he spent a great deal of time on his teeth, using various dentrifrices, mouth washes, and patent products for the treatment of pyorrhea. As this occupation continued, it became more intense, and the patient became more and more preoccupied with the problem of his teeth. He would think about it for hours and question every one whom he met about ways to save his teeth. His interest broadened so that to him the vital interest, not only in himself, but in others, became the status of the teeth. He would question members of his family and, indeed, chance acquaintances about their teeth and compare notes, as it were. This preoccupation was annoying to others and to himself, particularly when he found other men of his age or younger whose teeth were in better condition than his own. These feelings of jealousy and envy were particularly strong in regard to his brother, aged thirty-five. The brother is married and lives with his wife and children in the same house as the patient. He is a breadwinner and contributes to the support of the patient, who is out of work. The immediate family of the patient sensed that there was something unusual in the patient's attitude and felt that "his mind was slipping".

The patient is the oldest of a family of three children. He has lived with the parents without intermission. He attended school through the eighth grade and then began work. As a boy, he was healthy, but shy and backward about mingling with "the gang". He has a very vivid memory of his maternal grandmother, who had false teeth and who was wont to tell ghost stories to the children, removing her false teeth and making ugly faces. The patient remembers being frightened by his grandmother and says that ever since he has had a horror of false teeth.

The patient has always been an industrious worker and has taken pride in helping to support his now aged parents. He says, "I've always been a home boy, and count it my greatest pleasure to have been able to love and care for my parents." He has never felt like marrying, because of this parental attachment. He states that he began masturbation as a young boy and has struggled with it ever since. In recent years he has become very religious and has found help in this way in overcoming his sexuality. He states, "I've been in love a few times, but never engaged." One finds, on further questioning, that these affairs have been adoration from a distance, and that he has always lacked courage to enter into any courtship. He states, "I have a girl all picked out back East, and maybe if I'm not too old, I'll marry after my parents die." One finds on questioning that this girl is not aware of his plans; indeed, he has not seen or written to her for several years. On a few occasions he has sought intercourse with prostitutes, but these attempts have been failures as far as satisfaction is concerned.

When asked concerning his activities during the war period, he states, "I was a spy, if you must know," but further questioning brings out, "I worked on my own." He then shows considerable affective display with tears in his eyes when he relates the death of a "buddy" in France.

The patient's own reason for the anxiety displayed concerning loss of teeth is that he looks so badly without them and that he feels so self-conscious—feels that people are laughing at him, and so forth. He does not seem to feel that false teeth will help much—"people will still be able to tell I haven't any teeth".

Disposition: This case was seen by the psychiatrist in several interviews. The history was thoroughly gone into and an association of early masturbatory activity with the grandmother established. She had suprised the patient in masturbation and had thoroughly frightened him by threats of castration and of ill-health. The fear of edentulation was established as a displacement fear of castration. The patient's sexual maladaptation and feelings of organ inferiority on this basis had served to accentuate this fear. Completion of the dental plates was hurried up, and attempts are being made at present to enable this individual to make a better psychosexual adaptation, through readjustment, emancipation program, and so forth. The panic state rapidly resolved itself after a few interviews.

Formulation: Psychoneurosis—obsessive ruminative tension state.

Summary: This case was seen by the psychiatrist working in conjunction with a general medical clinic. A few interviews sufficed to identify the situation and to resolve the panic state. Further reports from the family indicate that the patient is getting along well. He has returned to work and no longer worries over his teeth.

During a brief experience of two months, the following cases, all of which had come to the out-patient clinic of the Colorado General Hospital, were seen by the psychiatrist in consultation:

Psychoneuroses (predominantly anxiety and obsessive ruminative tension states)	12
Toxic psychoses	2
Manic-depressive psychoses (both mild depressions)	2
Senile deterioration	2
Mental defect	2
Reactive behavior disorders (in children)	2
Paranoid reaction	1
Psychosis with cerebral arteriosclerosis	1

This work is continuing, with the psychiatrist as an integral part of the medical out-patient clinic. The cases are largely chosen by the medical staff for reference; the problem is then studied and identified by the psychiatrist and recommendations for treatment are made. Whenever possible, psychiatric therapy is instituted, particularly when it is felt that the con-

dition can be handled readily in the clinic. This work is associated with the regular teaching program and brings home to the medical students and to the fellow in training the intimate relationship of psychiatry to general medicine. Assignments are also made of several months' work in the neurological out-patient clinic.

We emphasize in our teaching and fellowship program the importance of recognizing the border-line conditions in which psychiatric problems are found in general medical and special practice. In the past, medical training, both undergraduate and graduate, has been poorly developed to meet the conditions of actual general practice and special practice. For instance, the practicing internist and neurologist may encounter in their work predominantly psychoneuroses and allied conditions, and yet medical schools devote very little time to these problems and considerable time to problems of organic neurology and the major psychoses. Moreover, fellowship training in psychiatry should not deal predominantly with advanced psychotic reactions, but should be concerned mainly with the neuroses and everyday problems encountered in the medical and surgical field, especially in pediatrics. We feel that one of the major developments in our fellowship-training program in the future will be the gradual dissemination of our special psychiatric training in the study of problems encountered in the medical, surgical, obstetrical, and pediatric clinics. It seems to us desirable to have each fellow gain some experience in a state hospital for mental disorders, and we are now seriously considering this addition to our program. However, the emphasis in psychiatry should be reversed from end stages to the study of early maladjustments in the home, the school, and the community.

SUMMARY AND CONCLUSIONS

We consider the essentials of a two-year fellowship training in psychiatry to be as follows:

1. The fellows should act as an integral part of the hospital staff, assuming direct ward responsibilities under the supervision of a senior psychiatrist.

2. They should have active out-patient responsibilities under supervision. The main emphasis of this work should

be placed on the child-guidance clinic, which insures opportunities to study the real beginnings of mental maladjustments of various types.

3. Each fellow should have an opportunity for active participation in community-clinic developments.

4. Opportunity should be provided for clinical research, for the study of criminals, for participation in the teaching schedules, and for combined work with other departments of medicine and the specialties.

5. A review of fundamental and current psychiatric literature is desirable.

6. At least three additional years of training or experience should be provided for.

7. It is to be expected that fellowship training of this type in psychiatry will stimulate many of our students to enter either teaching or clinical work in this field. This will be true in proportion to the success of our efforts to focus our attention on the early development of mental disorders, although it is important to give some time to the observation and study of end stages.

PARENTAL ATTITUDES AND MENTAL-HYGIENE STANDARDS *

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THE problem of parental attitudes is one that has assumed increasing importance in clinical psychology during the past few years. It has become a commonplace among those dealing with the behavior problems of children that one of the most difficult factors to be overcome in remedial treatment is the attitude of the parent in regard to his child.

Until very recently, however, attitudes have been considered inaccessible from the point of view of measurement, and none more so than parental attitudes. Their unapproachability has been frequently pointed out. Richards [1] writes: "I should like to discuss a few common parental attitudes that do a great deal of damage in the way of warping the development of childhood. These attitudes are equally common in all sorts and conditions of mothers and fathers. City and country bred, college and grade educated, foreign born and native aristocrat are equally prone to err when a discussion of their own children is concerned. Each set of parents excuses its attitude of rebellion against the acceptance of plain, straightforward facts by the rationalization of parental love. The only difference of class distinction is that the social stratum with better education and wider opportunities for so-called culture possesses a richer repertoire of defensive mechanisms."

It is probably this barrier, the "defensive mechanism", that has been so effective in warding off investigation into the field of attitudes. It has certainly been found very resistive to frontal attack. Recognition of this fact in recent

* The experiment reported in this paper has been supervised by Dr. Henry H. Goddard, Head of the Department of Clinical and Abnormal Psychology, Ohio State University.

[1] *Practical Aspects of Parental Love*, by Esther Loring Richards, M.D. MENTAL HYGIENE, Vol. 10, pp. 225–41, April, 1926.

years has led to the devising of indirect methods of approach. This technique has been found more productive of results.

Thurstone[1] has recently given us a workable definition of attitudes, and his lucid exposition of the principles of attitude measurement constitutes a valuable contribution to this relatively new field of psychology. He defines attitude as "the sum total of a man's inclinations and feelings, prejudice or bias, preconceived notions, ideas, fears, threats, and convictions about any specific topic". "The concept 'opinion' ", he continues, "will here mean a verbal expression of attitude. . . . It is the attitude that really interests us. The opinion has interest only in so far as we interpret it as a symbol of attitude. It is, therefore, something about attitudes that we want to measure. We shall use opinions as the means for measuring attitudes."

Another important principle set forth by Thurstone is one that should be kept in mind in the study of parental attitudes: ". . . we shall measure the subject's attitudes as expressed by the acceptance or the rejection of opinions. But we shall not thereby imply that he will necessarily *act* in accordance with the opinions that he has endorsed. Let this limitation be clear. The measurement of attitudes expressed by a man's opinion does not necessarily mean the prediction of what he will do. If his expressed opinions and his actions are inconsistent, that does not concern us now, because we are not setting out to predict overt conduct. We shall assume that it is of interest to know what people *say* they believe even if their conduct turns out to be inconsistent with their professed opinions. Even if they are intentionally distorting their attitudes, we are measuring at least the attitude that they are trying to make people believe they have."

Laws,[2] in her study to determine "how nearly a mother is likely to see her own attitudes and practices concerning her children as they appear to three other persons whom she considers competent to judge", found that "parents tend to rate themselves in their relation to their children and their

[1] *The Measurement of Attitude*, by L. L. Thurstone and E. J. Chave. Chicago: University of Chicago Press, 1929.

[2] *Parent-Child Relationships: A Study of the Attitudes and Practices of Parents Concerning Social Adjustments of Children*, by Gertrude Laws. New York: Teachers College, Columbia University, 1927.

practices concerning them somewhat lower than observers rate them". That is, mothers tend to rate themselves less constant, less gentle, less patient, than observers rate them on such traits.

In opposition to this attitude of *self*-depreciation, Laws found that "parents tend to rate the responses of their children somewhat higher than observers rate them, *except* when the response of the child is a source of continued irritation to the parent, or when it is subjected to higher standards by the parent than by the observers, or when the response is one in which a child is likely to make a better showing before persons outside of his family". In other words, mothers tend to overlook the faults of their children to a greater degree than observers do, except where the child's behavior (perhaps bad table manners) proves embarrassing or otherwise disagreeable to the parent.

These facts have been frequently pointed out by mental-hygienists. It is believed, however, that objective measures (other than clinical observation) applied to the field of parental attitudes should be of real value to those engaged in mental-hygiene practice, child guidance, and parent education. Need for further investigation along this line has been stated by a number of authorities. Williams[1] writes: "Much of the work of the child-guidance clinic must be directed at these home and parental situations rather than at the child itself. Not until the emotional currents, both obvious and subtle, that exist within the home of any given child are comprehended and evaluated can one hope to understand the emotional reactions of the child."

This project is concerned with the determination and evaluation of some of these significant forces centering about the child. A survey of the previous work in this field has led the writer to direct his investigations primarily toward those parental attitudes which have a very direct effect upon the *mental* and *social* well-being of the child.

[1] *Finding a Way in Mental Hygiene*, by Frankwood E. Williams, M.D. MENTAL HYGIENE, Vol. 14, pp. 225–57, April, 1930.

CONSTRUCTION AND ADMINISTRATION OF A SCALE FOR THE STUDY OF PARENTAL ATTITUDES

The material for the items in the attitude scale used in this study was obtained from several sources. These consisted in the main of several hundred case files from a child-guidance clinic, a number of books on child care and guidance, and lists of items obtained from individuals engaged in mental-hygiene and child-guidance work. From these materials, a scale was prepared in mimeographed form. This form was scored by a group of forty graduate students in the department of psychology at the Ohio State University. On the basis of the results from this trial group, the scale was revised. The result was a scale resembling somewhat Wickman's Schedule D.[1] It consisted of 70 items of child behavior to be rated from 1 to 10 according to the seriousness or undesirability of the behavior.

One hundred and sixty-seven of these printed forms were distributed among three groups of parents:

Group A.—a parent-teacher association in a high-grade suburban community of Columbus, Ohio. Of the 62 blanks distributed in the group, 52 were returned complete and 10 incomplete.

Group B.—a parent-teacher association in an average Columbus community. From this group of 72, 37 sets were returned incomplete because of (1) lack of time, (2) lack of inclination to finish, and (3) failure to comprehend directions. The other 35 sets were complete.

Group C.—a Sunday-school class of older married women of a downtown Protestant church in Columbus. Thirty-three blanks were distributed to this group, of which 23 were returned complete and 10 incomplete.

The data for the parent group, then, were obtained from 110 complete sets of the scale. Of this number, 95 were obtained from mothers and 15 from fathers. Comparisons between the various groups of parents represented in this study have not yet been completed.

If an element of selection enters in, it is probable that the parents represented in these groups are slightly above aver-

[1] *Children's Behavior and Teachers' Attitudes*, by E. K. Wickman. New York: The Commonwealth Fund, Division of Publications, 1928.

age as to intelligence and educational advantages as compared with the population at large.

One hundred and sixteen sets of material, consisting of a copy of the attitude scale and an explanatory letter, were distributed by mail to a group of mental-hygienists—well-recognized authorities in the fields of child psychology, clinical psychology, mental hygiene, and psychology of adolescence. Fifty complete, usable blanks were received from this group. Blanks marked by unidentified assistants were rejected, as were incomplete blanks—blanks with items unmarked—from both the parent and the mental-hygienist groups.

SCORING THE SCALE

The directions for rating the items were as follows: "Score each of the following items of child behavior as to seriousness or undesirability. *Work quickly. Do not omit any of the items.* Indicate your answer by drawing a circle around the appropriate number." The following examples of scoring were given:

	Of no consequence	*Of little consequence*	*Undesirable*	*Serious*	*Very serious*
Laughing	(1) 2	3 4	5 6	7 8	9 10
Murder	1 2	3 4	5 6	7 8	9 (10)
Crying	1 2	3 (4)	5 6	7 8	9 10

In general, three criticisms were expressed by the mental-hygienists who gave their opinions of the test. The first was that the directions do not specify a child of any particular age, and that certain items desirable in a four-year-old child might be undesirable in a twelve-year-old child and *vice versa.* The second criticism was that the test could not be adequately rated unless the rater had some particular child in mind. The third was that the scale allows only for degrees of undesirability, and consequently makes it impossible to indicate positive desirability.

In view of the above criticisms, it must be remembered that the scale was necessarily constructed with the idea of making it appropriate for parents of widely divergent educational background. It was not desired to construct a scale involving too complicated directions or terms unfamiliar to parents with little education. This necessitated the elimina-

tion of many possible refinements in technique which would have made the scale more involved and therefore more confusing for a large percentage of the parents whose ratings were desired.

A second consideration was that clinical contacts with parents led us to believe that the parent group would be much less conscious of such difficulties than the mental-hygienists, who are dealing with numerous individuals and who, as a result, have great respect for the value of individual differences. As a result of experience in administering the test to parents, we feel that this assumption was largely justified, since very few of the criticisms offered by the parents correspond to the first two criticisms of the mental-hygienists. A number of parents, however, expressed their desire for a method of indicating the positive desirability of certain items.

RATINGS BY PARENTS

The means of the parents' ratings of the scale (70 items of child behavior to be rated as to seriousness of undesirability) are shown in Table I.

TABLE I.—SEVENTY ITEMS OF CHILD BEHAVIOR RATED BY PARENTS AS TO SERIOUSNESS OR UNDESIRABILITY.

Original scale number	*Rank*	*Item*	*Average rating by 110 parents*	*Scale level*
14	1	Stealing	9.04	Very serious
50	2	Masturbation	9.03	
20	3	Lying	8.84	
34	4	Cheating	8.82	
41	5	Unreliability	8.69	
5	6	Disobedience	8.56	
40	7	Obscene talk	8.48	
37	8	Playing with fire	8.36	
26	9	Swearing	8.33	
47	10	Cruelty	8.25	
16	11	Smoking	8.15	
11	12	Tantrums (fits of temper)	7.81	
42	13	Sex experience	7.80	
28	14	Destructiveness	7.63	
35	15	Talking back (impertinence)	7.56	Serious
43	16	Cowardliness	7.46	
33	17	Unfairness	7.46	
25	18	Nervousness	7.43	
31	19	Bullying	7.40	
69	20	Biting, kicking, pinching	7.37	
63	21	Disrespect for elders	7.36	
65	22	Unresponsive to parental love	7.33	
12	23	Enuresis (bed-wetting)	7.18	
39	24	Selfishness	7.14	
19	25	Suggestible (easily influenced)	7.13	
60	26	Criticizes parents	7.05	
49	27	Rudeness	7.02	

TABLE I.—*Continued*

Original scale number	*Rank*	*Item*	*Average rating by 110 parents*	*Scale level*
32	28	Depressed	6.98	
30	29	Sulkiness	6.93	
64	30	Ungratefulness	6.86	
58	31	Contradicting his elders	6.86	
17	32	Fault-finding	6.85	
18	33	Fears	6.75	
38	34	Resentfulness	6.71	
6	35	Constant whining	6.70	
70	36	Argues when corrected	6.62	
8	37	Running away	6.59	
45	38	Giving up easily	6.56	
9	39	Carelessness	6.55	
44	40	Impoliteness	6.53	
36	41	Quarrelsomeness	6.50	
29	42	Withdrawing (not sociable)	6.32	
56	43	Interrupting adult conversation	6.30	
48	44	Careless of appearance	6.23	Undesirable
68	45	Bad table manners	6.14	
23	46	Stubbornness	6.12	
7	47	Suspiciousness	6.12	
53	48	Defiance	6.10	
2	49	Laziness about the house	6.09	
1	50	Tattling	6.02	
46	51	Uninterested, bored	6.00	
57	52	Forgetfulness	5.88	
13	53	Domineering (self-assertion)	5.81	
52	54	Fighting	5.79	
59	55	Criticizes playmates	5.73	
24	56	Demanding attention	5.62	
27	57	Sensitiveness	5.60	
55	58	Overactivity (restlessness)	5.50	
61	59	Bossiness (giving orders)	5.48	
4	60	Foolishness (showing off)	5.36	
15	61	Excessive modesty	4.96	
54	62	Likes to play alone	4.79	
51	63	Talkativeness	4.30	
67	64	Runs through the house; noisy	4.18	
22	65	Shyness	4.00	Of little consequence
21	66	Story-telling (imaginative)	3.97	
3	67	Bashfulness	3.88	
10	68	Daydreaming (make believe)	3.73	
66	69	Spends most of time reading	3.68	
62	70	Asks questions continually	3.65	
		Mean	6.57	

Here we see that the fifteen items of child behavior considered most undesirable by parents were aggressive, extrovert acts in direct conflict with the conventional code (such as stealing, masturbation, lying, cheating, and obscene talk), opposition to parental control (such as unreliability, disobedience, tantrums, and impertinence), and acts believed by parents to be of physical hazard (such as playing with fire and smoking).

The fifteen items rated least serious by parents have to

do with introvert, withdrawing behavior (such as sensitiveness, excessive modesty, playing alone, shyness, reading constantly, and bashfulness) and with child play and self-expression (such as demanding attention, over-activity, running through the house, and asking questions continually).

It is rather difficult to make any detailed generalizations from the items that the parents rate neither very high nor very low, but, in general, objection is raised to behavior that disturbs the quiet and routine of the household (such as bullying, biting, whining, quarreling, and tattling) and breaches of family etiquette (such as rudeness, selfishness, arguing, impoliteness, interrupting adult conversation, and bad table manners).

Several items of the upper portion of the middle group might be classified under the first group as "opposition to parental control"—for example, disrespect for elders, criticizing parents, and the like. A number of items at the lower portion of the middle group might be classified under the head of introvert, withdrawing behavior, such as fears, withdrawing, suspiciousness, and lack of interest.

Considering all the items, we find that parents regard *transgressions against morality and opposition to parental control* as more undesirable than *disrupting the quiet and routine of the household and breaches of family etiquette.* These in turn are regarded as more undesirable than *child play and self-expression and introvert, withdrawing behavior.*

RATINGS BY MENTAL-HYGIENISTS

The mental-hygienists' reactions to the scale are shown in Table II. The items that are regarded as most serious by this group relate to extreme introvert, withdrawing behavior (such as depression, fears, suspiciousness, withdrawing, cowardliness, and excessive modesty); unsocial behavior (such as cruelty, stealing, cheating, lying, bullying, and unfairness); and other indications of maladjustment or ill health (such as nervousness, constant whining, tantrums, sulkiness, and enuresis).

The items rated as least serious by the mental-hygienists are opposition to parental control (such as criticizing parents, arguing when corrected, disrespect for elders, contradicting

TABLE II.—SEVENTY ITEMS OF CHILD BEHAVIOR RATED BY MENTAL-HYGIENISTS AS TO SERIOUSNESS OR UNDESIRABILITY.

Original scale number	*Rank*	*Item*	*Average rating by 50 mental-hygienists*	*Scale level*
32	1	Depressed	8.02	
18	2	Fears	7.94	
47	3	Cruelty	7.68	
6	4	Constant whining	7.58	
7	5	Suspiciousness	7.57	
25	6	Nervousness	7.48	
14	7	Stealing	7.46	Serious
34	8	Cheating	7.44	
29	9	Withdrawing (not sociable)	7.42	
41	10	Unreliability	7.38	
11	11	Tantrums (fits of temper)	7.36	
43	12	Cowardliness	7.08	
20	13	Lying	7.06	
30	14	Sulkiness	7.00	
31	15	Bullying	6.96	
12	16	Enuresis (bed-wetting)	6.94	
33	17	Unfairness	6.90	
15	18	Excessive modesty	6.81	
45	19	Giving up easily	6.80	
38	20	Resentfulness	6.70	
39	21	Selfishness	6.38	
8	22	Running away	6.38	
28	23	Destructiveness	6.32	
69	24	Biting, kicking, pinching	6.22	
19	25	Suggestible (easily influenced)	6.18	
46	26	Uninterested, bored	6.14	
17	27	Fault-finding	6.06	
42	28	Sex experience	6.04	
40	29	Obscene talk	6.00	
54	30	Likes to play alone	6.00	
5	31	Disobedience	5.98	
24	32	Demanding attention	5.86	Undesirable
3	33	Bashfulness	5.86	
1	34	Tattling	5.82	
36	35	Quarrelsomeness	5.82	
55	36	Over-activity (restlessness)	5.74	
23	37	Stubbornness	5.56	
22	38	Shyness	5.54	
50	39	Masturbation	5.54	
27	40	Sensitiveness	5.46	
10	41	Daydreaming (make believe)	5.44	
13	42	Domineering (self-assertion)	5.42	
65	43	Unresponsive to parental love	5.32	
37	44	Playing with fire	5.30	
53	45	Defiance	5.26	
2	46	Laziness about the house	5.22	
9	47	Carelessness	5.14	
49	48	Rudeness	5.10	
35	49	Talking back (impertinence)	5.00	

TABLE II.—*Continued*

Original scale number	*Rank*	*Item*	*Average rating by 50 mental-hygienists*	*Scale level*
16	50	Smoking	4.94	
64	51	Ungratefulness	4.90	
26	52	Swearing	4.78	
61	53	Bossiness (giving orders)	4.76	
44	54	Impoliteness	4.58	
66	55	Spends most of time reading	4.56	
4	56	Foolishness (showing off)	4.52	
60	57	Criticizes parents	4.44	
70	58	Argues when corrected	4.40	Of little consequence
59	59	Criticizes playmates	4.32	
63	60	Disrespect for elders	4.30	
48	61	Careless of appearance	4.26	
57	62	Forgetfulness	4.14	
58	63	Contradicting his elders	4.04	
52	64	Fighting	3.92	
68	65	Bad table manners	3.82	
56	66	Interrupting adult conversation	3.80	
51	67	Talkativeness	3.28	
21	68	Story-telling (imaginative)	3.12	
62	69	Asking questions continually	2.58	Of no consequence
67	70	Runs through the house; noisy	2.44	
		Mean	5.68	

elders, and interrupting adult conversation); and child play and self-expression (such as bossiness, foolishness, fighting, swearing, talkativeness, asking questions, and running through the house).

The items rated neither very high nor very low by mental-hygienists overlap to a certain extent, as they did for the parents. In general, however, these items may be classified as transgressions against morality (such as obscene talk, sex experience, and masturbation), breaches of family etiquette, and disrupting the quiet and routine of the household (such as running away, fault-finding, tattling, quarrelsomeness, rudeness, and the like).

To summarize, we may say that the mental-hygienists regard *extreme introvert, withdrawing behavior and unsocial behavior* as more serious than *transgressions against morality, breaches of family etiquette, and disrupting the quiet and routine of the household.* These in turn are regarded as more serious than *opposition to parental control and child play and self-expression.*

COMPARISON OF RATINGS BY PARENTS AND MENTAL-HYGIENISTS

The items on which the greatest differences appear between parents and mental-hygienists on the ratings of a given item are shown in Table III.

TABLE III.—THIRTY MOST SIGNIFICANT ITEMS ON WHICH PARENTS AND MENTAL-HYGIENISTS DIFFERED.

A. Items serious to mental-hygienists, less serious to parents.

Item number	*Item*	*Rank given by mental-hygienists*	*Rank given by parents*	*Difference in rank*
15	Excessive modesty	18	61	43
7	Suspiciousness	5	47	42
3	Bashfulness	33	67	34
29	Withdrawing (not sociable)	9	42	33
54	Likes to play alone	30	62	32
6	Constant whining	4	35	31
18	Fears	2	33	31
32	Depressed	1	28	27
10	Daydreaming (make believe)	41	68	27
22	Shyness	38	65	27
46	Uninterested, bored	26	51	25
24	Demanding attention	32	56	24
55	Over-activity (restlessness)	36	58	22
27	Sensitiveness	40	57	17
30	Sulkiness	14	29	15
	Mean	21.99	50.60	28.66

B. Items serious to parents, less serious to mental-hygienists.

Item number	*Item*	*Rank given by mental-hygienists*	*Rank given by parents*	*Difference in rank*
26	Swearing	52	9	43
63	Disrespect for elders	60	21	39
16	Smoking	50	11	39
50	Masturbation	39	2	37
37	Playing with fire	44	8	36
35	Talking back (impertinence)	49	15	34
58	Contradicting elders	63	31	32
60	Criticizes parents	57	26	31
5	Disobedience	31	6	25
56	Interrupting adult conversation	66	43	23
70	Arguing when corrected	58	36	22
40	Obscene talk	29	7	22
64	Ungratefulness	51	30	21
49	Rudeness	48	27	21
65	Unresponsive to parental love	43	22	21
	Mean	49.39	19.60	29.73

These items are listed according to difference in rank, as rated by parents and by mental-hygienists. If we turn to Table I, we see from the second column of figures that parents rate stealing first—that is, as most serious. Table II

shows that for mental-hygienists stealing ranks seventh—that is, six other items are considered by mental-hygienists to be more serious than stealing. The difference between the rank of *seven* for mental hygienists and *one* for parents is *six*. This difference is hardly large enough to distinguish very effectively between the two groups, so this item is not listed in Table III.

The item *second* in rank of seriousness for parents is masturbation. This same item ranks *thirty-ninth* for mental-hygienists. The difference in rank is *thirty-seven*. This item is included in Table III. Further examination of this table reveals more clearly a tendency noted above—*i.e.*, for the mental-hygienists to rate as significantly more serious than parents rate them items of extreme introvert, withdrawing behavior, indicative of more or less serious emotional and social maladjustment. Parents, on the other hand, rate as significantly more serious than do the mental-hygienists transgressions against morality and opposition to parental control.

THE STRENGTH OF THE PARENTAL ATTITUDES

A comparison of the distributions of the average scores for parents and mental-hygienists lends further weight to the above conclusions. The mean of the seventy average scores for the mental-hygienists is 5.68. (See Table II.) The mean of the seventy averages scores for parents is 6.57. (See Table I.) Parents rate consistently toward the more serious end of the scale, 81 per cent of their items being above the midpoint (5.5) on the scale. The mental-hygienists rate only 56 per cent of the items above the midpoint of the scale.

Parents rate only 10 items as *of little consequence*. They rate 33 items as *undesirable*, 25 items as *serious*, and 2 items as *very serious*. Mental-hygienists, on the other hand, rate 2 items as of *no consequence*, 19 items as *of little consequence*, 35 items as *undesirable*, 14 items as *serious*, and none as *very serious*. These figures are summarized below:

	Number of items rated				
Rating	Of no consequence	Of little consequence	Undesirable	Serious	Very serious
By parents	0	10	33	25	2
By mental-hygienists	2	19	35	14	0

Parents, then, tend generally to rate child behavior, as indicated by this scale, as more serious or more undesirable than the mental-hygienist group does. When we consider, in addition, the nature of the items rated as serious by parents, we obtain an impression of what appears to be the central characteristic of the parental attitude—its highly repressive nature.

In addition to this relative disapproval of child activity, parents view repression and lack of social adjustment as of little consequence. They direct their strongest resentment against many of those forms of behavior that symbolize to the mental-hygienist an independence and aggressiveness in the child that are of prime importance for attaining real effectiveness in all phases of life—except that of being a "model child".

SUMMARY

We may summarize the findings of this investigation as follows:

1. Parental attitudes can be determined and measured by the method used in this study.

2. The test employed has disclosed a definite attitude which may be said to be characteristic of the parent group. The parental attitude differs to a marked degree from that of the mental-hygienist group.

3. The chief characteristics of parental attitudes as distinguished from those of the mental-hygienist group are:

A. Greater insistence on observance of moral taboos.
B. Greater insistence on parental authority.
C. Greater insistence on adherence to group standards and social customs.
D. Relative indifference to the effect that such insistence may have upon the child's emotional and mental adjustment to life.

IMPLICATIONS FOR PARENT EDUCATION

The question now arises: Are such findings of any significance for the field of parent education? In the light of this study, the following appear to be a few of the necessary

objectives of education for parenthood if it is to be of more than superficial value:

1. The parent must be aided to achieve a certain degree of insight into his own behavior, as a basis for sympathetic understanding of the problems of his child.

2. In order to acquire this capacity for sympathetic understanding, the parent must be brought to realize, first, that the motives behind his willingness to sacrifice the mental and social well-being of his child are the result of a grave misconception as to the origin and nature of moral customs; and, second, that the basis of his desire for forcing the child into strict observance of moral taboos are not as unselfish and disinterested as he imagines. He must be thoroughly informed of the fact that the taboos which he cherishes as divine creations are really the work of his primitive ancestors—and, as the products of man, are subject to intelligent consideration in the light of greater funds of knowledge and experience than were available when these customs originated. He must be warned that their primary function, as has been shown by Miller [1] and other authorities, is the domination, control, and often the exploitation of the individual by the group, of the weak by the strong. If the parent is ever to acquire a thoroughly coöperative attitude toward the child's task of maintaining an unrepressed, creative personality, he must first willingly sacrifice the sentimentality and superstition behind which he unconsciously retains the primitive prerogative of domination and exploitation of his child.

3. As this study has shown, even the parent of above average intelligence and social standing is relatively little concerned with the real mental-hygiene difficulties of the child. He very strongly disapproves, however, of the annoying symptoms of these maladjustments. Clinical experience has shown that he wants a direct attack made against such symptoms as temper tantrums, resisting parental authority, stealing, and the like. Since his conception of the more desirable qualities in a child are quietness and unobtrusiveness, he seeks to solve such problems by repressing the annoying

[1] *The Child in Primitive Society*, by Nathan Miller. New York: Brentano's, 1928.

behavior. He must come to realize that a real solution can seldom be effected by such treatment, and furthermore that this procedure is likely to aggravate the real conflict from which the child is suffering. Only by a thorough inoculation with some of the elementary principles of mental hygiene will the parent arrive at an understanding of the nature and origin of the child's conflicts and assume a tolerant and helpful attitude toward the symptoms of these conflicts.

4. The parent must be made more than superficially aware of the priceless value of an unmutilated child personality. In order to accomplish this, we must first help the parent to free himself from his own crippling repressions. We may enable him to become reconciled to certain of his own inadequacies, to seek satisfactory sublimations, or even to achieve some of his unrealized ambitions. Further, the resentment against, and desire for revenge upon the frustrations, maladjustments, and moral incapacitations that have been inflicted upon him must be directed where they belong—against the unwitting ignorance of parents, teachers, community—rather than expressed as unconscious jealousy of the freedom and activity of the child.

5. After the parent has attained real insight into his own motives and achieved a thorough respect for the rights of the child as a human being and as an individual—and not until then—he will be able to employ intelligently and without harm the various "methods" available for "handling behavior problems".

ATTITUDE TOWARD DEATH AND THE DEAD AND SOME POSSIBLE CAUSES OF GHOST FEAR

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THE suggestions here set forth toward an explanation of some attitudes toward death and the dead and of ghost fear, particularly among preliterate peoples, are offered as hypotheses and no more than that. While believed to be valid, they have not yet been proved; moreover, it is not claimed that if eventually proved, they will provide a complete explanation of the phenomena under consideration. It is felt, however, that the hypotheses advanced provide *partial* explanations and offer fruitful leads toward further study and investigation.

The preliterate belief in survival after death is sometimes based on such evidence as dreams, states of apparent death followed by return to consciousness (fainting, unconsciousness from injury), delirium, and so forth.[1] This belief in turn largely determines attitudes toward death and the dead and gives rise to ghost fears. The firmness of the preliterate belief in immortality is well described by Frazer: "The question whether our conscious personality survives after death has been answered by almost all races of men in the affirmative. On this point skeptical or agnostic peoples are nearly, if not wholly, unknown."[2]

Considering first the individual's attitude toward his own death, it may be said there are three possible emotional tendencies that are important: joy or gladness, indifference, and

[1] On this point see a fuller discussion by the present writers in "*Des origines possibles d'animisme*," *Revue internationale de sociologie*, Vol. 39, September-October, 1931.

[2] *The Belief in Immortality and the Worship of the Dead*, by J. G. Frazer. London: Macmillan and Company, 1913. Vol. 1, p. 33.

horror or fear. The first appears with relative rarity and need not concern us here.

Passive acceptance of death or indifference may be due to ignorance of its real meaning for the organism, as seems to be the case with children. Some preliterate groups show as much indifference as the child, if not more, albeit for different reasons. There are, for example, certain Australian natives who believe so implicitly in a future life that it is an act of filial duty for the sons to kill the father and the mother while they are still comparatively young and vigorous, so that their souls will have a corresponding amount of vitality and hence live happily in the spirit world. The parents themselves sit calmly on the edge of their graves waiting for the blow of the knobkerry that will mean death—and a future existence in the prime of life. Indifference to death is here obviously only a manifestation of a desire to live. Somewhat similar is the situation when the notion of death is a state of simple rest, a conception that plays a part in Christian ideology.

Such "indifference" may well represent diversions, euphemistic escapes-from-reality as a product of anxiety neurosis, and hence the very antithesis of indifference. Study of the actual attitudes of old people on the verge of death and of dying persons, however, shows a real indifference, comparative at least, contradicting the gruesome picture of the dying sinner formerly so dear to some clergymen.[1]

As soon as man realizes what death means to the physical organism, however, a great revulsion takes place if desire for life is strong and is not diverted or sublimated; in fact, Stekel has strongly urged that at bottom all fears are, when analyzed, fears of death. Watson's experiments on fear in infants show that the only external stimuli that cause what may be termed a fear reaction are sudden loud noises and sudden falls, which may well have been the specific kinds of fear that would help the infant to survive. A later development seems to be fear of a situation to which the organism cannot rapidly adjust, of what is strange and new. If fears that aid the organism in the struggle for existence can be called fears of death, then the infant and the child have the fear of death without conscious knowledge of death.

[1] See particularly "Thanatophobia and Immortality", by G. S. Hall. *American Journal of Psychology*, Vol. 26, October, 1915. pp. 554 *et seq.*

While some preliterate groups appear indifferent to death, others have an intense horror of it. Many authorities say that this horror is so widespread as to be practically universal—*e.g.*, Hartland [1] and Malinowski.[2]

Along with the possible inborn fear that man has in common with other organisms is a supplementary fear based on the idea of personality. Western man cannot face annihilation of the values he attaches to his own intellectual, emotional, and conative activities. When the belief in immortality is called in question, an almost morbid fear of death arises, or even true thanatophobia. Another manifestation is the fascination for most human beings in stories of death, which seem to owe their attraction to the latent ambivalence of many "normal" people. (The rôle of ambivalence will be discussed later in this paper.) The interest of the newspaper-reading public in every detail of executions is an instance.

The forms of behavior connected with death and its accompanying emotions, as with other crises of life, become "crystallized" in folkways and ritual that are of great importance not only to the dying person, but also to the survivors. The impressive Roman Catholic ceremony of extreme unction, for example, is fairly sure to set a pattern to which the survivors conform when their turn comes. Such ritual is secondarily a powerful instrument of social control.

II

The logical next step is inquiry into attitudes toward the dead. Those considered here are primarily such as are connected with animism, which is to say that fear will be the principal emotion dealt with. (Such fear may be ostensibly fear of the corpse alone; but to the animistic way of thinking, there is no "corpse alone", no body of the deceased without its corresponding spirit.)

As found in the infant and young child, fear of corpses is conditioned first of all by the unpleasantness of contact with the dead body, particularly the perception of unusual coldness

[1] See "Death and the Disposal of the Dead", by E. S. Hartland, in Hastings' *Encyclopedia of Religion and Ethics*. New York: Charles Scribner's Sons.

[2] See "Magic, Science, and Religion", by B. Malinowski, in *Science, Religion, and Reality*, edited by J. Needham. New York: The Macmillan Company, 1925. p. 49.

and the lack of movements of response. The result is a "total situation" that gives a feeling of strangeness, which, if strong enough, may be called fear. Other factors of strangeness in the total situation may be the peculiar and unfamiliar facial expression, the half-opened eyes, the unusual posture, the death pallor, and, as further and usually decisive conditioning factors, the shroud, grave clothes, coffin, and other funeral accessories. If to these stimuli there is added the social contagion of grief—tearful, silent, or vocal friends and relatives—the response to the total situation is immediate and unmistakable.

In the case of preliterates, we have again the element of strangeness, but the situation is much more complex. The revulsion is often a cultural phenomenon. The tribe has learned that those who stay near ill or dying persons themselves fall ill and die; crude notions of contagion and taboo expressed in terms of magic, and so forth, may result. They may believe in a ritual formula used by a secret enemy, the act of a god, or the curse of a powerful wizard as the cause of death. Any of these accredited causes may lead to shunning of the dying person, thus setting a culture pattern that may persist and evoke the emotion of fear when the original belief is in the limbo of departed superstitions.

In the absence of evidence to the contrary, however, we may also assume that the sympathetic suffering that illness and the death crisis may cause preliterate survivors accounts in part for "natural" revulsion. That there is sympathetic interaction even in the animal world is sometimes affirmed by those who have studied the behavior of chimpanzees and other anthropoids. Visual and other stimuli cause the perception of suffering and agony; this perception evokes a sympathetic reaction, which causes a degree of discomfort or suffering in the perceiving individual, and such suffering arouses the impulse to withdraw from the stimuli that cause the perception, this impulse having as its affective side the emotion of fear.

The revulsion that may be produced by the physiological phenomena of dissolution is well-marked. These phenomena have but to be named in the presence of many moderns to cause a shudder (whether instinctive, socially acquired, or conventionally enacted, we cannot say).

Among modern adults, fear of the dead as distinct from that of the corpse has a different set of predisposing influences. The fear of contagion instilled by training in elementary physiology, the "unnaturalness", and the element of "shock" play large parts. There is no good reason why the emotion of fear, the affective side of the workings of the autonomic nervous system—which gets the organism ready for flight—may not be evoked in the adult, even though he does not consciously feel as if he wanted to run away. Although the modern does not see the more gruesome physical consequences of death, some unusual circumstance or his imagination may supply an appreciation of them. The rôle of imagination has undoubtedly been very powerful. Our thoughts of the fate of the bodies of our friends have little to guide them save the traditional poetic abominations of putrescence, worms, and moldering to dust. Convention sternly checks reveries that may be thus aroused in the adult, and the inquiries of children, who often pass through a stage of interest in the fate of the body after burial, is either ignored or met with "Hush!"

The connection of morbidly painful imagination with repulsion is due to sympathetic reaction, "sympathy" here being used in the proper scientific sense of the word rather than the popular sense.[1]

III

Fear of the dead, morbid or otherwise, and exaggerated attention to the dead cannot be understood without the concept of *ambivalence*. This term, psychiatric in origin, means that hostile and affectionate feelings are directed toward one and the same object of interest. Either type of feeling may be dominant in an individual at a given time, and the dominance may shift from hatred to tender feeling and *vice versa*. Only one aspect of the ambivalence may appear at all in consciousness. Both the feeling consciously dominant and the forms of expressing the ambivalence are, of course, strongly influenced by social controls, by the group standards of what is appropriate to the circumstances.

[1] For a discussion of the phenomena commonly subsumed under the term "sympathy", see "Some Forms of Sympathy: A Phenomenological Analysis", by Howard Becker. *Journal of Abnormal and Social Psychology*, Vol. 26, pp. 58–68, April, 1931.

Diametrically opposite situations may through ambivalence present similar behavior patterns. For example, a neurotic man with an Œdipus complex may lose his mother by death. During her life his repressed complex may have led him to over-compensate in his conscious behavior in order to maintain freedom from affectional bondage, leading to continual quarrels; he hates her, so far as his ordinary attitudes and behavior go ("rationalization in terms of the consciously dominant attitude"). When she dies, the "necessity" for repression no longer obtains; the ambivalent feeling of affection comes to consciousness, dominates all his bereavement behavior, and leads to exaggerated mourning and funeral magnificence. The repressed drive can come to consciousness because a socially approved outlet is provided.

On the other hand, a neurotic woman married to a man she subconsciously hates may manifest an apparent love that becomes annoying because of the very excess of "loving" attentions. She cannot bear to be separated from him for an evening, and takes a too-solicitous interest in every detail of his life. His tie must be straightened, his rubbers must not be left behind on rainy mornings, his business associates must be taught his true worth; he is constantly smothered by his wife's clinging "love", all in forms having proper social sanction. At his death, the necessity for continued repression of the subconscious hatred is redoubled; for society recognizes only one approved form of bereavement behavior, and that must scrupulously avoid any appearance of other than tender feeling. Here the repression, as in the previous interest the expression, of the submerged attitude leads to extreme mourning and to prosperity for the "mortician".

This state of the emotional life is conspicuous only in definitely neuropathic personalities, although some psychiatrists say that practically no one can claim complete freedom—that there is a streak of ambivalence in all our personal relations, whether consciously dominated by tender feeling (essentially the life wish) or the opposite feeling of hatred (the death wish). There is no conclusive proof that ambivalence is a major factor in the attitudes of so-called normal persons, although it may be. Such a sweeping assumption is not necessary to explain the various customs plainly having an ambi-

valent element; one or two pronounced neuropaths in a tribe or community, if they hold positions of influence, would be enough to set up a culture pattern to which the group might conform. That among preliterate peoples neuropathic types often find socially approved outlets for their behavior in shamanism, and so forth, is well established.

Ambivalence affects the fear of the dead through the mechanism of projection. In the words of Freud, who first advanced it as an explanation of the fears here dealt with, "This unknown hostility, of which we are ignorant and of which we do not wish to know, is projected from our inner perception into the outer world and is thereby detached from our own person and attributed to the other. Not we, the survivors, rejoice because we are rid of the deceased; on the contrary, we mourn for him; but now, curiously enough, he . . . would rejoice in our misfortune and . . . seeks our death. The survivors must now defend themselves against this; . . . they are freed from inner oppression, but they have only succeeded in exchanging it for an affliction from without."[1]

As suggested above, only a few neuropathic individuals in a tribe would be needed to establish an ambivalent culture pattern; the almost unlimited power of shamans and priests is accorded them precisely because of their neurotic behavior. Projection of subsconscious hatred and consequent fear of the corpse, therefore, become ritualized. All dead persons should be regarded with dread; has not the priest said that the corpse of his dead father is trying to work him evil, and does he not show his fear in his own furtive glances and trembling hands? Are not all corpses evilly disposed and to be shunned, put out of sight, imprisoned in rock-hewn graves, dismembered, bound—in short, rendered incapable of working the malice they intend?

IV

Thus the corpse alone may be feared—but to the corpse fear arising in one or more of the ways that have been suggested, there must be added fear of the spirit of the departed,

[1] *Totem and Taboo*, by Sigmund Freud. New York: Moffat, Yard, and Company, 1918. p. 105.

inasmuch as most, if not all, preliterate peoples firmly believe that there is no such thing as a "corpse alone". Their implicit animistic belief leads them to assume that something once associated with the corpse survives; or one might perhaps better say, something of the individual. There is a spirit, which by its association with the corpse may share the fear aroused by the latter. Thus animism, implicit or explicit, provides an external "object" upon which may be projected the survivors' hatred and to which hatred toward them may be imputed; hence fear of the evil ghost perhaps arises with the linkage of animism and corpse fear.

These connections or linkages may have been established very early in the development of culture, for through the oldest myths runs the ever-recurring motif of evil "demons", and many eminent anthropologists say that these demons are none other than the ghosts of the departed. In fact, some authorities have been so impressed by the universal fear of ghosts that they hold the belief in definitely evil spirits to be older than the belief in definitely good spirits. Of course, the simple animatistic or animistic hypothesis has in it nothing that would determine the character of the unseen beings it postulates. This factor enters in only when men project their own feelings upon the ghost, as has already been outlined.

Leaving the hypothesis of ambivalence and projection in the background for the present, what are other reasons why ghosts may be feared? First of all may be placed the general fear of the unknown or the strange. Contributing to this fear of the unknown ghost is fear of the powers that animistic beliefs attribute to spirits, powers that are unknown and hence limitless. Consider the powers attributed to them even to-day, *e.g.*, independence of gravity, ability to pass through solid doors and walls, to cause levitation, to tap, rap, and sound musical instruments.

Besides these fears of the strange and unknown, fear of the supposed existence led by the ghost might lead by association to fear of the ghost itself. The death-crisis dread may tend to pass over in the survivors' minds to the hypothetical life of the ghost, and from that to the ghost. The apparent misery of the corpse, presumably shared by the ghost as it waits for complete decomposition of the corpse before it can be admitted

to the spirit land, makes the ghost restless, envious of the living, and hence malignant toward them. Hence also special classes of ghosts are feared more than others—*e.g.*, those meeting death by violence or a terrible illness, the murdered who pursue their murderers, and young lovers who die with their natural longings and desires unsatisfied.

Third, it may be conjectured that the desire for life plays a part. A fondness for this life may be a cause of aversion for the other; man dislikes to leave a world he knows and enjoys for one of which he is ignorant and afraid. We fear passage to another world, and by association we also fear the inhabitants of that other world. (Of course it is not true that *all* preliterate peoples fear death or the world to which it admits them.)

In later stages of culture, when painful mourning customs have been firmly established through the projection of ambivalent attitudes as previously described, there may come the belief that the ghost causes such torture or demands it as the price of benevolent neutrality. Thus the dead are not mourned because they are feared, but feared because they are mourned in painful fashion. (The explanation is scarcely satisfactory, but is included for completeness.)

Again, dead enemies, or their ghosts, may be feared because, according to animistic belief, they now have an increased power of vengeance through invisibility, ability to travel with the quickness of thought, and so forth. Ghosts may—and often do, according even to modern stories—come back to enforce justice as they see it. Here we get a projected guilty conscience. Thus the ghosts of those whom savages slay in war must be propitiated, so that they will not come back for revenge; those to whom secret injustice has been done and those who have been mistreated or abused in everyday associations because of inferior social or economic position now have superior power themselves and are especially feared.

In these latter classes of ghosts especially, the mechanism of ambivalence is manifest. The same mechanism affords an explanation of the fear of another class of ghost—that of near relatives or friends or those who have been benevolent in their lifetime. Many tribes believe that kindly persons become especially malevolent after death. This may well have arisen

from an instance in the tribe where a neurotic wife, let us say, forced by custom to refrain from hate behavior because of her husband's good repute, projected her hatred upon the ghost of the good husband, who then became the personification of all that is evil and malevolent.

We have traced various possible explanations of attitudes toward death and toward the dead, and some possible causes of ghost fears, primarily with relation to preliterate peoples. It goes almost without saying that the same mechanisms acting in "civilized" groups, or survivals in such groups of attitudes previously set up and culturally determined for the modern individual, may be found to-day. Particularly important is the rôle of ambivalence in producing corpse fear and, when linked with implicit animistic beliefs, in accounting for ghost fears. It should perhaps be repeated here that these explanations are not offered as complete, or as conclusively proved; moreover, any one or any combination may have acted in a given case to produce the phenomena observed.

INTEGRATION

My fingers pattern a symphony,
Whimsical, quaint, of industry;
The shining needle slips in, slips out
Like a silver horn; the cymbal's shout
Of dissonance clangs from pan against pan;
The thud of the iron sounds round about.

My irrelevant mind constructs a plan.

Apart from this surfacing melody
Of design and task, the essential me
Yields itself to the ecstasy
Of complete experience, suffers, sings,
Broods; atuned, is questioning
Enveloping worlds; is absorbed, remote . . .

I am synthesized by a single note
From without! In sudden harmony,
Thought and feeling and act are bound
Into one response; swift chords resound,
In released progression, triumphant, free!

Is the master key
To inner music reality?

JULIA WELD HUNTINGTON.

Norwich, Connecticut.

CRUCIFIXION

Oh, the honor of little children,
The loftiness of their spirit,
Their friendliness,
Their dignity,
The beautiful candor of their approach!

Oh, the grace of their young bodies,
The flow of movement through them—
Movement that neither begins nor ends,
Sweeping from loveliness to loveliness!

Our crookedness is a thorn on their bewildered brows;
Our ridicule is a nail in their flesh;
Our selfishness is a spear thrust in their sides;
Our indifference is vinegar on their wounds.

And yet, unasked, they forgive us even unto seventy times seven!

JULIA WELD HUNTINGTON.

Norwich, Connecticut.

ABSTRACTS

THE TREATMENT OF POST-ENCEPHALITIC CHILDREN IN A HOSPITAL SCHOOL. By Earl D. Bond, M.D., and Kenneth E. Appel, M.D. *The American Journal of Psychiatry*, 10:815–28, March, 1931.

In an effort to meet the special problem presented by children with post-encephalitic behavior disturbances, a school for such children was started five years ago at the Pennsylvania Hospital for Mental and Nervous Diseases. The recreational, occupational-therapy, and gymnastic facilities of the men's and women's departments were used, the boys and girls being handled separately. There was one schoolroom which was used by the boys in the morning and the girls in the afternoon.

The children were in charge of a graduate nurse with psychiatric training, who was assisted by both graduate and student nurses. Male nurses were used with the boys and female with the girls. For the school work, there was a teacher with special-class training. A music teacher conducted singing classes at regular periods throughout the week, and both boys and girls were given occupational-therapy work. A certain regular time was allotted to gymnastics and swimming. Tests were made at intervals by a psychologist, and several psychiatrists with a special interest in children supervised and coördinated the work as part of their regular hospital routine.

The endeavor was to provide a calm and unemotional psychological atmosphere for these cases. The psychiatric nurse, trained to regard irritating and antisocial behavior with impersonal understanding, was a great help in this, and an effort was made to inculcate the psychiatric point of view in all those who came in contact with the children. A spirit of optimism was maintained, and understanding and coöperation were stressed rather than criticism, discipline, and punishment. The children themselves were encouraged to feel that their difficulties could be cured like any other condition for which hospital treatment is necessary.

The day's activities followed a regular, though not a rigid schedule, as it was found that a regular routine eliminates much mischief through substitutive activities. To avoid the danger of over-supervision, a certain amount if time was allotted for free play, but experience proved that even during that period it was better to have a supervisor not too far away in case of emergency.

Regular grade-school work was carried on, with particular attention to individual difficulties and problems. The amount of work

done was probably about half or two-thirds of that accomplished in the ordinary school. The group was found to be lacking in initiative and originality in spite of their restlessness, which was met by keeping them busy every minute. Recitation periods were short.

In addition to group treatment, much work was done with the individual children. At varying intervals conferences were held at which the problems of the various children and the best methods of meeting them were discussed by teachers, nurses, psychologists, and psychiatrists. The main object of these discussions was to get the whole personnel to thinking of the child's reactions in terms of his needs—to turn their attention from the irritating behavior manifestations to the deeper issues involved.

As a method of gaining insight into the minds of these children, a great deal of time was spent in establishing an intimate relationship with them individually and encouraging them to tell stories, relate their phantasies and dreams, and make drawings. Very interesting material was secured in this way, revealing the inner thoughts and attitudes of the children. The subject of sex was taken up naturally and frankly. One of the books read during the reading period was De Schweinitz' *Growing Up,* and it was noticed that after the reading masturbatory practices and much of the filthy talk on sex and menstruation decreased to insignificant proportions.

The authors feel that the results of the treatment are encouraging. Of 48 post-encephalitic and 14 non-encephalitic behavior cases, all but three were able to learn by experience and to improve to a fairly satisfactory level in the hospital, and of 20 cases sent home, 7 have continued to improve. There is reason to believe that the outcome will be equally favorable for some of those still in the hospital school.

The important thing in these cases is not the overt behavior—the lying, stealing, undesirable sex habits, and so forth—but the underlying feelings of insecurity, the regressive tendencies, and the intense extro- and introversions. The physical disease, encephalitis, left handicaps that these children were not able to cope with psychologically. Placed in a favorable psychological environment, under a healthy régime of rest, occupation, exercise, and diet to build up their physical condition, many of them are able to win control.

DEMENTIA PRAECOX; A SIMPLIFIED FORMULATION. By R. G. Hoskins, M.D. *The Journal of the American Medical Association,* 96: 1209–11, April 11, 1931.

Dr. Hoskins argues here for a practical, working conception of dementia praecox that will be comprehensible to nurses and attendants of psychiatric hospitals and other laymen who come into close contact with the patient and in whose hands his welfare largely rests.

To such people, the complex and technical formulation of the disease that is necessary from the point of view of the trained psychiatrist is merely confusing and discouraging, and their efforts in behalf of the patient are stultified by their complete lack of understanding of his problems. This, in Dr. Hoskins' opinion, is one of the reasons why so little progress has been made in the therapy of dementia praecox.

The conception that he suggests to serve as a practical basis for therapy is expressed in the following set of directions for nurses and attendants which is in use at the Worcester State Hospital:

"(a) Dementia praecox is an intermittently or continuously persisting dream state. To cure the patient, he must be brought back to reality. Get him interested enough to stop dreaming.

"(b) The psychosis results from an intolerable feeling of loss of self-respect. This is due to a feeling of failure of the individual to meet his own personal standards.

"Build up his self-respect.

"Self-respect in the patients can be increased:

"1. By correction of personal standards, if these are wrong.

"2. By encouraging personal neatness and cleanliness.

"3. By treating each patient as respectfully as you would want to be treated if you were in his place and he in yours. Draw a skillful line between friendliness and offensive familiarity. Consider the patient's background. Remember he is insane because he is sensitive.

"4. By encouraging the patient to keep his personal quarters as attractive as possible.

"5. By respecting his personal belongings and protecting him in the use of them.

"6. By encouraging the patient to do things that he himself will respect.

"7. By encouraging him to be helpful to others.

"8. By giving the patient as much responsibility as he can and will carry without being disturbed or fatigued.

"9. By building up good physical health.

"(c) Dementia praecox is characteristically accompanied by a feeling of isolation. Draw the patient out of himself. Encourage him to take a self-respecting part in community life. Teach him that the best way to have friends is to be a friend—especially to those who need friendship.

"(d) The psychosis serves ordinarily as a protective reaction. Do not expect the patient to give up his protection as long as he needs it."

ABNORMAL LABOR AS AN ETIOLOGICAL FACTOR IN MENTAL DEFICIENCY AND OTHER ASSOCIATED CONDITIONS: ANALYSIS OF 20,473 CASES. By Neil A. Dayton, M.D. *New England Journal of Medicine,* 203:398–413, August 28, 1930.

To test the theory that difficult labor is an important etiological factor in the production of mental deficiency, an analysis was made of a consecutive series of 20,473 retarded school children examined by traveling psychiatric school clinics in Massachusetts. The items considered were intelligence quotient, school accomplishment, order of birth, number and type of physical defects, height, weight, diagnosis, social conduct, and personality traits. Abnormal labor was defined to include (a) prolonged labor, (b) instrumental delivery, and (c) difficult labor, and an I.Q. below 70 was considered indicative of mental deficiency as distinguished from mere retardation.

For purposes of comparison, 125 Massachusetts obstetricians were asked for estimates as to the incidence of abnormal labor in the general population. The average percentage obtained from them was 70. In the study group, percentages were estimated for the two sexes separately in the two sub-groups—the mentally deficient and the retarded. Among the mentally deficient, a history of abnormal labor was found in 13 per cent of the boys and 11 per cent of the girls; and among the retarded, in 14 per cent of the boys and 12 per cent of the girls. The figure for the general population is probably high, owing to the fact that obstetricians are likely to have a high percentage of difficult cases in their practice, and to the further fact that they are apt to insist upon treating their patients in hospitals, where facilities for instrumental delivery are readily available. But even allowing for this, there is little evidence that mental defectives and retardates are more likely to have been born under abnormal conditions than the general population; rather the contrary. Moreover, the percentage of cases with histories of abnormal labor is higher for the retardates than for the mental defectives. Incidentally, the sex difference is of interest, the percentage of abnormal birth conditions being 2 per cent higher among the boys than among the girls both in the mentally defective and in the retardate group.

In the matter of degree of intelligence, no apparent association was found between abnormal labor and the group of intelligence quotients ranging from 30 to 79. There was, however, a suggested association with the I.Q. groups 0–29, 80–89, and 90 +, particularly the latter. Dr. Dayton feels that "the negative finding of a lack of association between abnormal labor and the great bulk of cases of mental deficiency is of little moment in comparison with the positive finding of an association between abnormal labor and the dull-normal or low-normal groupings. The far-reaching significance of the latter finding

lies in the fact that the bulk of our population lies in these higher levels of intelligence."

As was to be expected, a very definite association was revealed between abnormal labor and first births, but this association was no more marked among the mental defectives than among the retardates.

In the physical field, a suggested association (not statistically significant) was found between abnormal labor and physical defects four or more in number. A definite association was demonstrated between abnormal labor and neurological defects, and there was a suggested association with skeletal defects in the I.Q. group 0–69, and with circulatory defects in the I.Q. group 70 +. No correlation was demonstrated between abnormal labor and underweight, and so far as height was concerned, a definite association was found between abnormal labor and above-average height.

The findings were negative for an association between abnormal labor and any of the various clinical groups (microcephalus, mongolism, cretinism, etc.), and between abnormal labor and such undesirable social conduct as delinquency, lying, stealing, sex offenses, and so forth, but an apparent relationship was established between abnormal labor and the personality traits of seclusiveness, egotism, over-affectionateness, and emotional instability, particularly the last. A significant dissociation was found between abnormal labor and the characteristics sociability and obedience.

In general, the findings of the study indicate that "whatever effect birth trauma may have upon the various factors studied, it appears to exert this influence impartially upon both groups, whether mentally defective or not mentally defective". Further study, Dr. Dayton feels, is needed of the relationship between abnormal labor and dull-normal intelligence, and between abnormal labor and physical and emotional characteristics. The latter relationships may, he suggests, be of more importance than the relationship with certain grades of intelligence.

BOOK REVIEWS

DIE ANALYSE DES ANALYTIKERS UND SEINER ROLLE IN DER GESAMTSITUATION. By Otto Rank. Leipzig und Wien: Franz Deuticke, 1930. 139 p.*

This is the third and final volume of Rank's *Tecknik der Psycholanalyse,* the first volume of which, *Die Analytische Situation,* appeared in 1926; the second, *Die Analytische Reaction,* in 1929.

In the first book, Rank presented his conception of the analytic situation as the therapeutically important factor in analysis, in contrast to the recalling or reliving of past experience by the patient. According to this view, all material offered by the patient, including dreams, whether its reference be to the past or to the local environmental situation, can be understood and therapeutically utilized only when its present meaning for the analytic situation is recognized and made the central point in treatment. Not the theoretical interpretations of the analyst, not the digging up of past causes and infantile fixations, but the patient's realization, acceptance, and active taking possession of his own present experience finally enable him to make connection with the denied or distorted past. The patient is fixated on the past, not because he loves it so much, but because he fears the present. By going beyond content to the dynamic interplay of forces in the analytic situation, the analyst can give the patient an opportunity to live in the present, something he has never dared to do before.

The emphasis on the biological relation to the mother, rather than the later social relation to the father, as expressing the underlying meaning of the analytic situation for every patient arose from Rank's experience in terminating analyses by setting a definite ending in advance. From the insight gained in this way, he came to the conclusion that, for the patient, separation from the analysis is always a birth, which can be utilized constructively from the first day, not by presenting the birth-trauma theory to the patient, but by using this deepened understanding of the analytic relationship to allow the patient to work through a gradual separation experience creatively instead of reacting to it as a trauma.

In Volume II, *Die Analytische Reaction,* Rank examines the reactions of the patient in analysis to determine their therapeutic value. He discards transference, catharsis, the making conscious by inter-

* This review is reprinted by permission from the *Psychoanalytic Review,* October, 1931.

pretation, and reëducation as having little to do with therapy. Love the patient has tried before and it has failed him; catharsis is but temporary relief; interpretation only adds to a self-consciousness already destructive; reëducation implies a making over by the analyst which no adult ever permits. For Rank the only therapeutic agent in the analytic situation is the clash of wills which inevitably occurs whenever one person puts himself under the will of another, even though he comes voluntarily seeking help. The neurotic, whose will to submit is always balked, nevertheless is not able to assert his will positively. At a point in this will conflict where the willingness to submit, to take help is uppermost, he comes to the analyst, whose task it is to see beyond the resistance to the potential strength it masks, which, if it can become positive, will itself bring about cure. In other words, resistance is not something directed against the analysis to be broken down by the analyst's superior right, but an expression of the negative will of the patient, which can become positive only gradually, as the analyst more and more leaves to the patient the positive and himself becomes the negative will.

Will, for Rank, is the integrated personality as original creative force, *that which acts, not merely reacts,* upon the environment. Rank's "will" has nothing in common with the Freudian "wish" in that it is *actually effective,* not a *passive element* in a deterministic chain. The will of the individual, as Rank conceives it, is in itself a first cause and produces something new. Its expression in the dreams of the patient goes beyond the wished for, but unattainable to the newly affirmed capacity for control already realized. Will is not merely the drive of a predominant instinct or combination of instincts; it is that central integration of the forces of the individual which exceeds the sum of the parts, a unity that can inhibit, as well as carry through to realization, the instinctual urges. Only the individual whose will is locked in negativism is obliged to fear his own impulsive self. Once the patient has recovered the use of his own will, he can bear to become conscious of denied impulses. They no longer threaten him any more than the objects of the outside world, since both have become material for the successful use of the will, as well as the possibility of defeat.

The rôle played by the therapist in bringing about this will organization on the part of the patient is developed in the present volume, *Die Analyse des Analytikers.* Rank's original intention, when this title was chosen at the time the *Technik* was first planned, was to analyze the analyst as a type, just as he has analyzed the neurotic type. While retaining the title, he has actually chosen to analyze the analytic process as a whole, to determine its general or symbolical meaning for the neurotic individual, and to discuss in

the light of that meaning the rôle that the analyst must accept if he is to function therapeutically, and not merely oppose to the patient's ideology of illness his own ideology of cure.

The book is divided into two parts. The first is devoted to a purely psychological presentation of the neurotic as a definite human type to which we all belong. The therapeutic aspects are treated only in the second part, which considers the analytic situation as social in the sense of a therapeutic reality in which the neurotic type utilizes the therapist type as his complementary opposite to work out his will conflict.

This division of the material indicates the sharp line that Rank draws between theory and therapy, the mixing of which he considers the cardinal error in psychoanalytic development up to the present. He attributes this error primarily to the failure to discriminate between knowledge and experience. The neurotic is helped, if he is helped at all, not by the technique or psychological theory of the analyst, but by the actual experience he undergoes, in terms of feeling and willing. This is transformed into conscious therapy only if the patient, not the analyst, is made the central figure of the analytic treatment, and the analyst accepts the rôle of assistant ego. From this point of view the analyst becomes the tool, the material which the patient shapes and reshapes in accordance with his need. It is this creative use of himself, which the constructive therapist permits, rather than the analysis of the patient in terms of a psychoanalytic ideology, which differentiates Rank's dynamic therapy from what he calls "ideological therapy". The patient, too, comes with an ideology, which needs to be met not by counter theory, but by the reality of emotional and creative experience.

This at once brings up two problems—the possibility of learning a technique of analysis and the implications of this position as to the nature of the neurotic individual. Rank is frank to admit that for such a conception of analysis, no definite technique can be provided, since the particular technique required differs with every patient and with every hour even for the same patient. This is inevitable, since technique proceeds not from the psychological theory of the analyst, which would predetermine the method, but from his ability to meet the creative demands of the patient at any particular time, which cannot be determined in advance, as they must needs contain something new, something unique to him. This amounts to saying, not that knowledge and skill are not necessary, but that they are not enough. In the last analysis, whether or not the therapist functions constructively depends in large part on the kind of person he is and his ability to subordinate himself to the rôle of assistant.

It is evident that Rank has given here a picture that quite reverses the ordinary attitude toward the neurotic, since he sees in the neurotic, not an individual who has failed to attain average adjustment, but an individual who never will attain such adjustment because he is potentially the creative artist type. All that therapy can hope to do is to release him to fulfillment in his own terms, rather than to hold up social norms which he has always used to destroy himself and which deny the very difference he has to learn to affirm if he is ever to take over responsibility for himself. This means that it is an error to think of the outcome of analytic treatment as cure. There can be no cure—since life is always painful and problematic and from this the neurotic cannot be protected—but only a rebalancing of forces, whereby living in the present, in reality, becomes possible.

Rank sees in Freudian psychology this setting up of a norm of individual development which, when applied to the neurotic type in ideological analysis, results in a determination to cure, to make the neurotic over into something he cannot and will not be. The length of Freudian analyses is thus a function of this necessity to reach a norm and for that purpose to bring out all the historical content needed by the analyst to complete his interpretative task. Naturally there is no good or easy way to decide when a sufficient amount of content has been explored or when the patient has actually reached the goal and will stay put. For Rank the ending is a matter of dynamics, not content, and is determined by the patient himself, when his utilization of the therapist has reached a point where he no longer wants an assistant ego, but a reality upon which to exercise his will.

From Rank's point of view, this ideological normative therapy applied to the neurotic, for whom it was totally unsuited, has finally brought about a technical impasse in Freudian analysis which has led to an overemphasis on the negative reactions. Freud finds in resistance, in guilt and desire for punishment, and in the so-called "repetition compulsion", the indications of therapeutically insurmountable forces, which have led him to the theoretical assumption of a genuine masochism as the expression of a "death instinct". Rank is spared this necessity by seeing in the individual, not merely an ego tyrannized over by id and super-ego, but an own will not derived solely from parent identifications nor blindly driven by the forces of the id, a will, which, if permitted, has within itself the power to create its own therapy.

It is impossible to indicate in a brief review Rank's critical discussion of the more recent problems in Freudian psychology, particularly the question of the "death instinct". Suffice it to say that he sees in this concept chiefly a rationalization of death fear, which

can always be found in the individual, and whose importance for all of us is so great that only denial could account for the tendency to ignore it.

In presenting Rank's theory of fear, I shall abstract from my own translation with only the general reference to the chapter, *Lebensangst und Todesangst,* in the original. "The fact that the freeing or satisfaction of sexuality does not necessarily do away with fear, but often even increases it, and the observation that the infant has fear at a time when there can be no question of outer threats of any kind, have made the theory of the sexual origin of fear and its derivation from the outside untenable. The individual comes to the world with fear and this inner fear exists independently of outside threats whether of a sexual or other kind. It only attaches itself easily to experiences of this kind, which, however, the individual makes use of therapeutically as relief, in order to particularize and make partial the general inner fear. Man suffers from a fundamental dualism and not from a conflict created by false social prejudices which can be avoided by a 'correct' bringing up or removed by later reëducation (psychoanalysis).

"The inner fear, which the child experiences with the birth process (or perhaps brings with it?) has in it already both elements, fear of life and fear of death, since birth, on the one hand, means the end of life (former life), and on the other hand, brings with it the fear of the new life. The stronger emphasis on the one or the other of these two fear components in the birth act itself seems to me still to contain the empirical meaning of the birth trauma for the later fate of the individual. Beyond that, however, the birth trauma for me was also symbol of the original suffering nature of man which, according to the psychoanalytic conception, had been caused in the first place by some fault of the individual or of the environment and could hence be corrected therapeutically or prophylactically (educationally). . . . The fact is just this, that there is in the individual a primal fear which manifests itself now as fear of life, another time as fear of death. . . . The fear in birth seems to me actually the fear of having to live as an isolated individual. . . . That would mean that primary fear corresponds to a fear of separation from the whole, therefore a fear of individuation, on account of which I should like to call it fear of life; that it can also come in later as fear of the loss of this dearly bought individuality as fear of death, of being dissolved again into the whole. Between these two fear possibilities, these poles of fear, the individual is thrown back and forth all his life, on which account one could not succeed in tracing back fear to a single root and in overcoming it therapeutically."

Rank presents the neurotic as an individual of unusually strong instinctual drive, who, through excessive fear, is unable to solve his conflict by creative expression, but is caught between his fear of life and the equal fear of not being able to live at all. The punishment tendency so conspicuous in the neurosis, Rank interprets not as the bribe that the id offers the super-ego, but as the attempt of the fear-driven individual to buy himself free of the final punishment by daily partial self-destruction. Self-punishment seems to express the individual's effort to control his own fate, even death itself, by taking over the administering of pain.

In the next chapter, *Total-Ich und Partial-Ich,* Rank develops psychologically and analytically the philosophic part-whole concept in its relation to the neuroses and the basic fear problem. This is perhaps the most original and interesting contribution of this third volume, but it is worked through with a fineness of detail combined with a universality of application that makes it almost impossible to condense without misrepresentation. The primal fear is conceived as derived on the one side from the part, separated from the whole and condemned to live alone, on the other from the necessity of giving up the individually attained wholeness to death. The embryonic state is, therefore, the symbol of wholeness, totality, in which the individual felt himself to be, not only an indivisible whole, but also part of a greater whole. In birth the child experiences a double trauma, the loss of the greater whole and the necessity of giving up its own indivisibility before the invasion of the external world. Rank uses the term "partialization" for this adaptation to reality. The child has lost its larger whole and has not yet achieved an ego unity of its own with which to meet the partialization required by living. Wholeness in ego feeling, once achieved, is a protection against the primal fear, but is again subject to the substitute fear of death, loss of individuality. Good average adjustment means ability to live partially, without wanting to preserve or give out the whole ego undivided in every experience. The above-average person may succeed in putting out that ability creatively, but frequently such an attempt results in neurotic shattering through (1) throwing into every experience, however unimportant, the whole ego, through fear of losing it partially otherwise (life fear); or (2) by keeping the whole ego apart from life in general (death fear).

Since fear is a forward-driving force as well as an inhibiting one, the neurotic who, through fear of losing his ego, dares not undertake life can also be driven out of his ego-bound state only through fear. The neurosis contains within itself both the destructive and the healing tendency, which requires for eventuation only a change of emphasis, not real alteration, the shift from the death side to the

life side, which can ensue in the overcoming of fear by a therapeutic solving of the part-whole problem in the analytic situation.

All neurotic symptomatology is an unfortunate part-for-whole solution, which distinguishes itself from normal partialization through this, that every part again becomes symbol of the whole and accordingly cannot be given, since for the neurotic the whole is totality, finality, hence death. The typical neurosis presents the individual who has killed a part of his ego in order to protect it from being lived out, through which he has made himself incapable of living. The hysterical type represents the death symptoms carried out in the own ego; the compulsion neurotic represents the fear of death projected upon the other. Accordingly, life is restricted in order to keep off death, but this repression of life is again only death, which the extreme compulsion type also acts out in his self-seclusion exactly like the hysteric in his attacks.

Technically, a resistance of the patient during treatment, always according to his type or the momentary localization of his fear (life or death), may be directed against an attempt at partialization through the analyst, or also against a compulsion to totalization. In the first case the patient will either resist the analytic partialization by (narcistic) total exclusion or he will react with (life) fear; in the second case, he will seek to avoid a synthetic compulsion to totalization, as it ensues through the increase of transference emotion, with a symptomatic partial payment.

On this account the reappearance or first appearance of symptoms in analysis cannot be met effectively through their historic genetic tracing back, but must first of all be understood from the dynamics of the therapeutic situation itself, which then also throws a light upon their general meaning in the total economy of the personality. In general, the first part of the analysis should unroll itself in terms of the (narcistic) total resistance to the therapeutic partial invasion, while the second may be characterized in terms of the "part" holding its own against the totalistic emotional binding through the appearance of partial resistances (transitory symptoms). Extreme resistances of either kind are to be avoided by the alternate letting come into play and the simultaneous clearing up of both factors.

In the chapter entitled *Krankheit und Heilung,* Rank concludes his theoretical presentation of the neurotic type with a discussion of the meaning of illness in general and its specific value for the neurotic. He goes beyond the conception of libido satisfaction combined with self-punishment to the therapeutic usefulness of illness as a means of renewal, and sees in the neurosis the misuse of nature's remedy. Neurotic illness represents the individual's attempt to create himself *in toto,* with the refusal to accept anything as given, which

results in a destructive instead of a constructive exercise of will. The important thing, however, is that, although negative, it is still an expression, not of id or super-ego, but of the own will, and cure is resisted because it is thought of as an end to individual willing, a taking over of normality as an alien domination, which would be death. It is the task of dynamic therapy to accept the creative striving which is hidden under the neurotic symptomatology and by allowing the individual to create his own analysis, to turn the negative will into a positive expression, whose destructiveness can be utilized legitimately in the final abandonment of the analysis.

The function of emotion in this process, which is as essential as the will psychology for understanding Rank's therapy, cannot be presented briefly, nor is there space to give his classification of types on the basis of emphasis and distribution among the three factors, fear, impulse, and will. The therapist and the neurotic, in Rank's view, constitute two complementary types, which means that the therapist finds in the neurotic and, therefore, tends to despise there his own destructive ego, while the neurotic looks for his creative ideal completion in the therapist. Each uses the other for his own purpose, but for therapy to ensue, the patient must finally go beyond identification to the acceptance of the own self in its difference.

The second part of Volume III is confined to therapeutic issues and discusses the rôle of the analyst in detail, the therapeutic necessity for end-setting, and finally the therapeutic function of reality and the social order for the individual.

The analytic process is initiated not by any activity on the part of the analyst, but by the new dynamic situation within the patient, which is set up by the initial projections of various, usually abhorred aspects of the self upon the analyst, which effects another economic division of energy. The analyst, in accepting and responding on the basis of the rôle assigned to him, permits the patient to play out his ambivalence and his own resistance to it within this larger unity, which contains the divided self and renders it bearable. The analytic task is to receive and finally guide the projections back to the ego of the patient.

The development and admission of emotion plays an important part in this outcome, since it represents a voluntary inhibition of impulse instead of denial or blind projections and offers an acceptable payment for the selfish use of the analyst, which would otherwise only increase the guilt. Emotion is peculiarly valuable in that it admits the "other", is social in its reference, while at the same time it is primarily a total realization of the self, so that its apparent dependence is consistent with the strongest possible sense of ego unity, thus paralyzing the partialization fear.

Rank conceives of the analytic situation as offering to the neurotic a "plane of illusion" such as the normal individual finds in art, religion, work, and the like, on which he can be sufficiently released from fear to learn to live, less earnestly, less painfully, less totally; not that the process will feel like illusion to him, for it will be of his own choosing and, therefore, as real as any of our scientific, social, artistic, or professional refuges from primitive living.

The basis of this illusionistic utilization of experience is the emotional life, which permits the modern man to realize, without actually living it out, the meaning of his own inner reality. It is, therefore, to the emotional development that the analytic situation turns for the creation of the individual illusion which the particular patient requires for living. It is just the neurotic who has been unable to take life partially and, therefore, to live at all who must learn to use substitute goals, partial feelings, limited satisfactions such as analysis can provide.

The relating of this play level to real living takes place, of course, gradually from the first moment if the analyst has in mind such an understanding of the meaning of analysis, but the critical point in dynamic therapy is to be located in the final phase, the ending, to which, from the first hour, the patient has been gradually working. The end-setting for Rank is not just a means of shortening the analysis nor an announcement of cure, but the most important therapeutic instrument available for treatment of the neurosis. Since every separation has in it for the neurotic individual the very essence of what he has found impossible in life—that is, growth—the fear of ending, as final separation or death, has to be transformed in the analytic experience into an acceptance of the ending as a beginning, a birth. This is possible only when the therapist understands and interprets the struggle of the patient to be free, not as impotent wish, or resistance to analysis, but as the expression of his own will, which finally conquers fear enough to want individual life at the point where emotional recognition of the dependence upon the analyst is at its height. That this separation is symbolized by death as well as birth is not strange, for to the patient, the analytic situation is the neurotic self which he struggles to kill, to leave behind, as well as the new self that wants to go on. Therapeutically, then, it is highly important that this delicate balance be not undone by the therapist's natural resistance to playing the negative self, which is to be overcome or killed off, a rôle that goes against his own creative psychology.

The ending is determined individually for every patient on the basis of the use he is making of the analyst, and of his readiness, even though disguised as resistance, to give up the assistant ego

and accept in its stead a reality on which the will can be exercised. This facing of the ending slowly, in advance, without sudden shock or evasion, permits of a gradual growth of the power to give up the assistant ego, to take over the own self, and allows the analysis and the analyst to become real, in that they now present a reality problem. The patient faces in himself and in the analysis the kind of ambivalence that characterizes reality, in terms of his will to go and his emotionally accepted dependence on the analyst. He has a real choice, which is like the choices he must make in the outside world, but not a final or fatal one, since outside reality offers the material for which his newly won will already longs, and emotional realization has given him the assurance of inner unity which he lacked before.

It is just here, in this shift of emphasis from reality as something that restricts and forbids libido expression to reality as that which the will needs for its completion, that Rank indicates his final thorough-going difference from the Freudian school. For him the chief therapeutic task, as he states it finally in the last chapter, *Der Individuelle und der Soziale Aspekt,* is not the adaptation of libido to reality, but, first, the acceptance of the own self with its individual ego and its volitional and emotional autonomy. Reality is therapeutically necessary to inner stabilization, not an unavoidable evil which one must accept because one can do nothing else. For if we had not reality, we should not only be shut off from the most pleasurable experiences, but, what is far more important, we should all have to create within the denials, limitations, hindrances, which we need for balance. The solution for the fundamental dualism of man is to be found only in reality, not in a reality opposed to the ego, but in a world of which the ego forms a part and which on the other side itself forms a part of the ego. The therapy of the neurotic can be no purely psychic affair. Psychotherapy can only bring him to the point where he himself can utilize reality therapeutically, not because he must, but because he needs it for harmonious balancing. For the only therapy is real life, and the patient must learn to live, to live with his split, his conflict, his ambivalence, which no therapy can take away, for if it could, it would take with it the very spring of life itself.

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THE COMMON SENSE OF DRINKING. By Richard R. Peabody. Boston: Little, Brown, and Company, 1931. 191 p.

This is an excellent book on the problems of intemperance, its causes and its treatment. Dedicated to Courtney Baylor, an outstanding pioneer in the treatment of intemperance, whose work

started with the Emmanuel Church under Doctor Elwood Worcester, it represents a study and treatment of many hundreds of cases.

The title is poor, as the book is concerned not so much with the common sense of drinking as with the common sense of not drinking too much. It is divided into four sections: *The Condition, The Diagnosis, First Steps* (of treatment), and *The Cure Made Effective.* A short bibliography is also included.

We have all recognized that the treatment of alcoholic conditions has in the past been most unsatisfactory, and in the writer's experience the medicinal cures have been far from permanently effective in the vast majority of cases. Segregation in an institution has also left much to be desired.

Mr. Peabody's book gives in a good deal of detail a new approach to the problem of alcoholism. It represents a careful attempt to evaluate the type of men and women who cannot drink moderately without indulging to excess. It points out very definitely how often alcoholism represents an escape mechanism and serves as a shock absorber for individuals who are finding difficulty in their adjustment to life's problems. The psychologist and the psychiatrist have long been convinced of this mechanism as the causative factor in the production of the excessive drinker. Mr. Peabody, who is neither a psychiatrist nor a psychologist, has been extraordinarily successful in the rehabilitation of the alcoholic. He tells us in clear and convincing language how this has been done, explaining how the individual problem is estimated; how the individual drinker must be got to understand the mechanism of the problem; how without a desire on the part of the patient to free himself from the habit, treatment proves in the main ineffective; how new and more constructive methods of meeting the problems are built up; how new interests are fostered; and how gradually the patient is taught to meet difficult situations by himself without recourse to alcohol.

The part of psychoanalysis in the understanding of the mechanisms in drinking is mentioned and while the psychoanalytical approach to these problems has not been used by the author of this book, nevertheless, he states, "I do not question the fact that the fundamental motivating cause of alcoholism may often be a conflict buried in the unconscious." He then goes on to say, "But experience has shown others besides myself that methods more or less similar to those set forth in this book are in general adequate for cure without more intricate psychoanalytical investigation." Perhaps when he writes his next book, Mr. Peabody will have learned more about this approach for some of the difficult and unsuccessful cases.

The present volume represents a most important contribution to the subject of excessive drinking. It gives a better understanding

of this previously neglected field of abnormal human behavior. The book should be read by all physicians, by the growing group of persons interested in the general problems of human behavior, and by those for whom alcoholic over-indulgence is a personal problem, as well as by those who have in their family, business, or social situations friends struggling with this serious disorder.

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RECONSTRUCTING BEHAVIOR IN YOUTH: A STUDY OF PROBLEM CHILDREN IN FOSTER FAMILIES. By William Healy, M.D., Augusta F. Bronner, Edith M. H. Baylor, and J. Prentice Murphy. New York: Alfred A. Knopf, 1929. 325 p.

There is no more valuable contribution to the field of social work than a frank inquiry into the results of what we practice. Five hundred and one children, known to one or more agencies over a period of years, were placed in foster homes as a therapeutic measure to cure (1) delinquency, (2) personality problems, (3) habit problems, or any combination of these.

Preliminary to a discussion of the outcome of treatment, the authors create a general background for their readers. Thus there is consideration of the various problems presented by the children, with attention both to their causes and to the treatment of them. Part III, on the technique of child-placing, warrants careful reading. It offers particularly pertinent discussion of such questions as the rôle of the visitor, the selection of the foster home, the relation between the placed child and his own family, replacements, and final discharge.

Throughout the book, the subject matter is treated with thoughtfulness, thoroughness, and sympathy. However, while the environmental factors that lead to problems in social adjustment are heavily stressed, direct treatment of internal conflicts, beyond a first catharsis, is greatly minimized. It is, in the main, the authors' belief that removal from the sphere of disturbing associations will in time permit successful adjustment. It is of interest, therefore, to find that, while the percentage of successes in the foster homes and after discharge is extremely high, the largest percentage of failures falls in the group suffering from "abnormal mentality or personality", either alone or in combination with delinquency. That the frequency of successes is so large is proof of the careful selection of children to be placed and of foster homes to be used, as well as of the patience, wisdom, and social-mindedness of all the experts involved.

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DISCOVERING OURSELVES—A REVIEW OF THE HUMAN MIND AND HOW IT WORKS. By Edward A. Strecker, M.D., and Kenneth E. Appel, M.D. New York: The Macmillan Company, 1931. 306 p.

Discovering Ourselves adds another to the list of popular volumes on applied medical psychology. The object is to contribute to the "general need of a more intelligent understanding of mental hygiene". The authors make the point that just as increased knowledge of physical hygiene by the general public has led to more complete development and security for the body, so a more extensive knowledge of mental hygiene in like manner should serve the mind.

The book is written exclusively for the laity and especially for the uninformed laity. There is an attempt to present the A B C's of the subject and much of it is in primer terminology. Short chapters with descriptive headings and brief summaries make for easy reading. Many diagrams serve to clarify obscure subjects for the visual-minded.

In general, the first third of the book is concerned with the authors' conception of modern psychology and leads up to the central topic of the three major "complexes", those of ego, self, and herd, respectively. Mental conflict, according to the authors, results from the opposing claims of these three complexes. Satisfactory adjustment of conflict means health; the opposite leads to neurosis.

The remainder of the book discusses separately the various mental schemes by which the ordinary individual deals with his own conflicts. It is pointed out that most of these mental reactions go on spontaneously and automatically without much awareness or self-direction. The conflict-solution methods are listed as follows:

1. Regression
2. Extroversion
3. Introversion
4. Rationalization
5. Segregation or the Development of Logic-Tight Compartments
6. Repression
7. Dissociation
8. Conversion of Mental Conflicts into Bodily Symptoms: Anxiety, Neurasthenia, Hysteria
9. Displacement or Substitution
10. Projection
11. Identification
12. Inferiority and Compensation
13. Sublimation

A chapter on each of the above procedures outlines the features, good or bad, that it contains. All of them to a certain degree are suspect except the last one, sublimation. This method offers a more

adequate means for conflict adjustment and is summarized on page 293 as follows:

> "We have now almost concluded the story of the various methods which the human mind utilizes in order to escape the frank facing of the conflicts or mental hazards which result from the warring of our complexes. At some time in our lives and to some extent we all use one or the other of these methods. Nevertheless, they are all crutches that enable us to walk mentally. Some of them are well constructed and sturdy crutches, quite serviceable and useful. Others are uncertain and unreliable. A few are sure to smash. And they are all crutches. There is one way of walking without crutches—walking mentally upright. It is called sublimation.
>
> "According to the dictionary, to sublimate means to refine or to purify. Psychologically, it may be taken to signify the utilization of instincts, desires, and tendencies in approved ways—ways approved by self and by the herd. It is really a process of education of instincts, desires, and tendencies, so that they will work according to acceptable and accepted standards. In sublimation there is a refinement of the crude; a raising to higher personal and social levels."

The therapy that is favored throughout the book is that of greater self-knowledge concerning both the nature of mental conflict and the various means of dealing with it. Confidence is reiterated that such self-knowledge will do much to make possible the avoidance of compromise and evasion and the attainment of more constructive methods of mental adjustment.

To write a book on abnormal psychology in the popular vein is at the best a difficult task. The conception and plan of the work under review are excellent for its purpose, but there are some important criticisms as to the way it is carried out.

There is a certain dogmatism, which is perhaps necessary for the scheme, but which will make it difficult for the reader to differentiate between formulations peculiarly the authors' own and those of more generally accepted validity. There is little reference to authority, and no documentation whatever. For example, Freud is hardly mentioned by name, in spite of the fact that nearly all the terms described in the thirteen methods of meeting mental conflicts were coined or appropriated to their present use by him or his immediate followers. A short discussion on psychoanalytic therapy on page 76 is wholly unsatisfactory from any standpoint, whether that of advocate, intelligent critic, or the uninformed. By statement or implication, a therapeutic potency hardly warranted by modern conceptions of psychopathology is attributed to an easily attained self-knowledge and self-determination. The book seems paradoxical in that it is both too elementary and not elementary enough. Some of the material, particularly the illustrative clinical material, is simple

to the point of naïveté, but interspersed with it is other matter only to be grasped by the more initiated. One suspects that readers who might profit by the latter would be too far along the path of mental hygiene to have any need of the former, and *vice versa.*

On the whole, the book is disappointing in comparison with what might have been expected from a contribution to popular literature by the two eminent psychiatrists who are its authors.

MARTIN W. PECK.

Boston.

THE TREATMENT OF BEHAVIOR DISORDERS FOLLOWING ENCEPHALITIS; AN EXPERIMENT IN REËDUCATION. By Earl D. Bond, M.D., and Kenneth E. Appel, M.D. New York: The Commonwealth Fund, Division of Publications, 1931. 163 p.

The object of this book is well stated in the introductory paragraph: "The purpose of this book is to describe the treatment given to a number of children whose characters had been damaged by encephalitis. An indirect purpose is to call attention to the occurrence and treatment of behavior disorders which may follow any kind of mild brain injury."

This experiment in reëducation was carried on in the Department for Mental and Nervous Diseases of the Pennsylvania Hospital, the oldest hospital in the United States. Originally no specially equipped building was available; however, under the new plan the children's quarters will be part of the new institute for mental hygiene.

The authors stress in particular the relationship with the child. "It must not be cold, academic, or aloof. There is a spirit of optimism about difficulties, which the children absorb." To this end much attention was devoted to the establishment of rapport. Tact and resourcefulness are stressed as a *sine qua non* in working successfully with these children. Contact was made through the reading of story books and the telling of stories, and through play of various kinds. Staff conferences were utilized as a means of comparing and correlating observations, opinions, and suggestions.

The authors state frankly that no one school of psychologic thought was followed to the exclusion of all others; rather a pragmatic approach through the several theories was utilized. Each child was individualized and the effort in treatment aimed at meeting that child's needs. Yet it should be noted that the authors found that "from the point of view of administration, it is significant that after a time the class fitted into the hospital régime without friction".

That the effort is well worth while is evident from the analysis of results: "Forty-six out of forty-eight post-encephalitic children and thirteen out of fourteen controls improved while at the hospital."

Needless to say, when these youngsters are returned to their former social environment, the percentage of definite improvement is much smaller. However, the following quotation states plainly the worthwhileness of the treatment and training received within the institution: "These figures show that of twenty post-encephalitic cases (excluding the feebleminded) sent home, seven, or 35 per cent, made a good adjustment, as compared with total failure of post-encephalitics placed in foster homes as reported by Healy."

The book sets out clearly what may be accomplished in the proper setting. It should be read by all mental-hygienists. Its contents must become widely known in order that "adequate provision for another group of unusual people, perhaps the most appealing group, because it contains many attractive and intelligent children", may be made in the immediate future, to care for the many victims of encephalitis now in prisons and mental hospitals for adults or at large in the community, where their problems are misunderstood and mishandled.

HENRY C. SCHUMACHER.

Cleveland Child Guidance Clinic.

EXPERIMENTAL SOCIAL PSYCHOLOGY. By Gardner Murphy and L. B. Murphy. New York: Harper and Brothers, 1931. 709 p.

Every competent book is likely to contain at least one chapter to repay study by all who have any connection with its field. In this case the chapter is that headed *The Biology of Motives,* which makes the much needed distinction between fact and formulation in psychology in a manner that both novice and indoctrinated may contemplate with profit. The topical divisions are of interest in themselves, as the way in which the material shaped itself in this its first organization. *Nature and Nurture in the Causation of Individual Differences* takes up the work on twins, social levels, and cultural and sex differences. *The Learning Process in Social Situations* is heavily weighted with the work on suggestibility. *Methods of Studying Social Behavior in Children* discusses principally the work of Gesell, Jones, Buehler, Thomas, and Newcomb, with emphasis rather on techniques. The long chapter *The Development of Social Behavior in Early Childhood* adds to these several other investigators, including considerable Russian work, and with more of an eye to findings. *Social Behavior in Later Childhood and Adolescence* includes *Middletown,* Hartshorne and May, much other material of ethical bearing, leadership, play, fancy life, and vocational problems. *The Individual in the Group Situation* is mainly concerned with competition and some other group influences, including the specifically emotional. *The Coöperating Group* studies varieties in coöperative

interaction, group-versus-individual problem solving, conflict situations. *An Introduction to the Measurement of Personality* begins at the subhuman level, briefly discusses individual differences in a somewhat structuralist fashion, and takes up methods of biographical ratings and numerous more strictly experimental procedures naturally directed at special traits. In *Social Attitudes and Their Measurement,* Goodwin Watson, Thurstone, Moore, the Allports, Bogardus, Lapiere, and Hunter are prominent figures. The volume concludes with remarks on propaganda, with special reference to Lippmann's "stereotypes".

It is not to the purpose to describe in detail the content of a volume like this, but he is a well-informed reader indeed who will not, for every one study that he misses, find others of equal relevance that are new to him. It should be emphasized that the descriptions of work in the field under consideration are far more than digests; they are critical evaluations, with due regard to relationships. Various techniques are compared and improvements in them are traced. From this standpoint especially, the volume merits careful study by any one contemplating research in its field.

One puzzling detail, in view of Murphy's well-known historical interests, is the treatment of rating-scale origins. It is a technique without which, in its ramifications, experimental social psychology could scarcely exist. Its foundations as a psychological method were laid by Cattell early in this century in such papers as *Statistics of American Psychologists*[1] which to-day equal in importance any work that has been done since. Yet the name of Cattell is not in the index. One is rather reminded of Nietzsche's remark on the consequence of following too closely on the heels of truth.

It is obviously hazardous to criticize as such the material presented in the volume, even though the book's presentations bear *prima facie* evidence of accuracy and fairness. The ever-present danger in experimental social psychology is a sacrifice of insight on the altar of statistics. Witness the glib multiplication of scales of introversion-extroversion—categories that have a lurid past and that break to pieces under close study of actual personality traits. The very spelling extroversion is ominous.[2] It is well enough to talk of "thinking to the point of testing—yes", but strong is the tendency to illusion as to where that point is located. Care must then be exercised in carrying over to a clinical setting conclusions reached in mass observations of this type. Attitudes can be measured—indeed Cattell

[1] *American Journal of Psychology,* Vol. 14, pp. 310–28, July–September, 1903.

[2] Of interest to one of the authors may be this firm seizing of the horns of the dilemma by an eminent authority: "This data have been punched on Hollerith cards . . . ." (*Social Science Abstracts,* 1931, No. 14745).

did it years ago; but the interpretation of the psychogenic factors that lead to the attitudes cannot be measured, and it is with them that the clinician must concern himself.

From individualistic standpoints also, the question from time to time presents itself as to possible damage to the mental hygiene of subjects in certain types of experimentation in this field, and, in general, as to the effect that its considerable instrumentalization of human material is likely to have on the ethical status of these investigations.

The writing of this book is a deed of no small courage as well as industry. To select from the welter of relevant studies a material of enduring value, to integrate this into a presentable pattern for which there is no previous work to serve as guide, is a task worthy of the greatest energy and acumen in our discipline. It follows that there is no standard to which the work can be closely compared. The impression is of an adjunct indispensable to the study of social psychology from whatever angle, and the reviewer cannot say how or by whom it would have been surpassed. The publishers are also to be congratulated on the manner in which they have seen to the work on the physical side.

F. L. Wells.

Boston Psychopathic Hospital.

Parent-Child Relationships; Outlines for Group Discussion. By Ruth Andrus and May E. Peabody. New York: John Day Company, 1930. 168 p.

These outlines for group discussion in parent-child relationships are an outgrowth of the program of parent education carried out by the New York State Education Department from 1927 to 1930.

The attempt is made to present this theme to leaders of mothers' study groups by means of ten study units, each with a bibliography and large numbers of excerpts from the literature attached. The study unit includes a statement of the objective for that meeting, a series of questions or "discussion guides", and some suggested projects or "experience guides" intended to activate principles deduced from the study.

Undoubtedly during the course of the discussions in which these outlines were crystallized into shape, many parents attained new insight into the significance of their parenthood, and leaders also, faced with the new human problems presented to them and with the necessity of helping the parent to meet them, became educated in a most vital sense.

However, the outlines as printed convey nothing of this vitality. They remain detached and academic. True, the reader is reminded

that only through constant use can the leader become proficient with them. But there is little to invite her to make the attempt. One feels that the authors sense this pedantic quality and have attemped an orientation toward "processes", on the one hand, in their use of the ideas of "discussion guides" and "experience guides", and on the other, in the manner in which the question series have been organized. One would welcome profuse illustrations taken from minutes of actual meetings, showing how these outlines were utilized in practice in the guidance of actual discussion and actual questions, and how these discussions and questions were modified by the differing educational and social backgrounds of the various study groups. However, the present book may well serve as one of the useful guides for leaders in parent education, while we await the book on parent-child relationships that will successfully combine child study as a science with child study as a fine art.

RUTH BRICKNER.

Child Study Association of America.

RITUAL. By Theodor Reik, with a Preface by Sigmund Freud. Translated from the Second Edition by Douglas Bryan. New York: W. W. Norton and Company, 1931. 367 p.

This fascinating book by the German analyst, Reik, is indispensable to sociologists, anthropologists and, of course, theologians. But it should be of especial interest to the psychologist because it shows what a great contribution his science—when not confined to phenomenological description—can make to other systems of knowledge. Psychoanalysis, the only science that goes beyond psychological phenomenology, was born, as Professor Freud says in his remarkably precise preface to Dr. Reik's book, of medical necessity, but it soon discovered that it could not rightly limit itself to individual psychopathology. Art, literature, normal behavior became the proper subjects of the science. As Professor Freud says, "And now it became an irresistibly tempting task—indeed, a scientific duty—to extend the psychoanalytical methods of investigation from their original field to more distant and diverse spheres of mental interest." Psychoanalysis came to include "the whole mental content of human life within its sphere".

The marriage of psychoanalysis to anthropology must be of great advantage to both sciences; anthropology needs a penetrating psychological approach, and psychoanalysis has an opportunity to check up the universality of its conclusions. The eminent Hungarian ethnologist, Dr. Róheim, rightly regards anthropology as a branch of knowledge that has still to become a science. So far, the study of primitive man has been largely descriptive and all too often

limited by subjective evaluations and inhibitions in the observation of psychological phenomena, for even in description a study must fall short of adequacy so long as it remains oblivious to fundamental psychological phenomena. Compare Reik's treatment of puberty rites, couvade, Hebrew ritual, and so forth, with that of even such outstanding non-analytic anthropological investigators as Frazer and Robertson Smith—and note the difference.

The significance of the psychoanalytic method in anthropology and of the treatment of ethnology as a division of psychology—of group psychology—is fully evident from even the briefest review of non-Freudian approaches to myth and ritual. It will be observed that solar (Frobenius, Carus), meteorological (Max Müller), vegetational, and totemistic (Frazer, Robertson Smith) explanations of ritual are incomplete and optional, two or more explanations sometimes seeming to suit the same phenomenon almost equally well. Furthermore, they are steeped in primitive and civilized rationalizations, and are colored by the intellectual approach of the ethnologist. A particular ritual may very well be a representation of the death and resurrection of some solar, vegetational, or totemistic deity, but not until we have arrived at the psychogenesis of the ritual can we make any pretence of having understood it.

Totem and Taboo contained the first formulation of the Freudian view, founded upon the observation of the close association between the fear of incest and primitive ritual—a view that Professor Freud has taken pains to repeat in his Preface to the present volume and that, therefore, doubly bears his approval:

> "God the father at one time walked incarnate on the earth and exercised his sovereignty as leader of the hordes of primitive men until his sons combined together and slew him; . . . the first social ties, the basic moral restrictions, and the oldest form of religion—totemism—originated as a result of and a reaction against this liberating misdeed."

Dr. Reik's book is an application of the psychoanalytic theory of ritual to specific problems, such as the couvade or male child-bed, puberty rites among savages, Hebrew ritual, and the origins of music dancing, and drama. The result is a remarkable clarification of some fundamental forms of religious performance, showing the procedure of the psychoanalytic method in ethnology and revealing the promise of its application to human problems.

Thus couvade is shown to represent a sublimation of hostile feelings toward the wife and the newly-born child, the custom—prevalent only among semi-primitive men—marking the breaking up of the primitive Œdipus complex and the conversion of hostility into concern. This is the basis of the many taboos observed by the father on the ground that what he does may injure the child. The father also

pretends to be in labor while his wife is giving birth, on the assumption that this will lessen the pain of the actual parturition. Like the general increase in human tenderness, couvade, then, is seen to be the product of intense repression, exhibiting the same mechanism of displacement that is found in neuroses; for example, in the excessive concern of an hysterical patient for the welfare of an individual toward whom he entertains hostile wishes in the unconscious. Originally the child appears as an incarnation of the slain father, and the mingled feelings of hostility and fear are reawakened by the sight of the child. The belief in the transmigration of the soul is really an intellectualization of the fear of retaliation by the murdered father who punishes his son for coitus with his wives by reappearing as the product of the union. A brief statement cannot do justice to Dr. Reik's hypothesis of the first stages in the evolution of ritual. Its main points are that the original murder of father was succeeded by murder of the first-born (taken for father), in which infanticide was a repetition of the original parricide. Remorse setting in resulted first in sacrificial killing of the child—sacrifice of the child (father) to father (another example of id-super-ego alliance or simultaneity of opposite satisfactions). This was followed by the substitution of an animal (likewise representative of father) in the religious sacrifice; hence the development of totemism.

Dr. Reik's examination of the puberty rites of savages reveals a similar psychological mechanism. Circumcision at puberty is a castration threat against the maturing boy, from whom the father must have originally expected castration or death, having himself done this by act or by thought to his own father. The puberty rites are a threat, an expiation (by the fathers as well as their boys), and a reconciliation with the fathers and new identification with them, followed by formal acceptance into the tribe. This is the significance of the ritual of the devouring of the boys by the totem monster amid a fearful noise, of their being circumcised (a partial killing and castration), and of their being finally reborn. An analogy is drawn between the death and resurrection of many deities, like Attis, Adonis, Dionysius, and Osiris, and the devouring and rebirth of the boys at puberty. The death of these deities is an expiation of the original sin of son against father, and, therefore, they are worshiped as redeemers, taking upon themselves the primordial guilt which persists in the unconscious of both primitive and civilized man.

The remaining topics of the book are subjected to similar dynamic psychological treatment, stripping off rationalizations and bringing the basic factor into clear light. The Kol Nidre ritual is viewed as a rebellious abrogation of the treaty (B'rith) with God, and as a repetition of the original parricide and atonement for it. The

blowing of the shofar or ram's horn in the synagogues is interpreted as a triumphant identification with the divine voice as well as a reconciliation with the slain and worshiped father and his totem representation—the bull.

Mention should be made of the brilliant, but perhaps a trifle strained, theory of the Moses legend as founded upon a son-god and totem ritual; of the study of music as an imitation of the voice of the totem or god (father); of dance as representing the life and sufferings of the sacrificed god; and of drama as an outgrowth of the dance, owing its cathartic value to the spectator's identification with the suffering god, due to the spectator's own sense of guilt. The investigation again shows "parricide . . . and its expiation to be the most important events in the development of primitive man. . . . At the beginning of human morality and religion we find the sense of guilt, that creative force which can never afterwards be extinguished."

It is possible that the treatment should have taken more account of primitive matriarchy and of the participation of women in ritual, as, for example, in the rites of Tammuz and Dionysius. Without an explanation of these subjects, the hypothesis that views ritual as revolving about the father-son relationship would seem to be incomplete. It would be interesting and important to investigate the Œdipus-complex basis of ritual in the light of matriarchy and feminine participation in ritual. At the same time, this would do justice to the inherent bisexuality of man and would satisfy the "complete Œdipus complex".

Moreover, the author's desire to penetrate to fundamentals sometimes leads him into explanations that, though very likely and valuable, skip over such matters as the psychogenesis of seasonal rites and seasonal elements in the worship of deities like Adonis and Osiris. An explanation of these topics would round out our understanding of a subject which Dr. Reik treats only from the point of view of resemblance to puberty ritual. Dr. Reik, however, does not pretend to have exhausted the subject.

It is a unique experience to observe the neatness of the author's procedure—the careful collection and collation of facts, the critical presentation of non-analytical explanations, and the penetrating exploration of the underlying psychological content of these facts in the light of psychoanalytical study of the neuroses. Dr. Reik never loses sight of this relationship, which is equally important to an understanding of ritual and of the neuroses, neuroses differing from religious psychological processes in the weakening of the social factor and the corresponding intensification of the sexual one. The author rightly sees the neuroses as caricatures of constructive achieve-

ments, just as he regards obsessional neurotic ceremonial as a caricature of religious ceremonial. Human nature is thus seen as a unity, the preposterous dualism of assuming one kind of mind for civilized and another for primitive man being exploded.

The book naturally has bearings upon religion. Those who believe that religious matters should be exempt from scientific investigation will resent this book. It will be better for them not to read it. Nevertheless, the book can hardly be construed as an attack upon religion. On the contrary, no one reading it will be satisfied with the agnostic view of ritual and dogma as examples of priestly imposition upon the credulity of man. The view that finds at the root of ritual the profound workings of the Œdipus complex, with its primordial sin, triumph, repentance, and desire for redemption, *ipso facto* admits the closeness of religion to *human life.*

The book is adequately printed and well indexed. The translation by Douglas Bryan is fluent, precise, and forceful.

Dorian Feigenbaum.

New York Psychoanalytic Society.

The Psychology of Exceptional Children. By Norma V. Scheidemann. Boston: Houghton Mifflin Company, 1931. 520 p.

The comprehensive nature of this excellent text is indicated by the chapter headings: *Nature and Origin of Trait Differences; Concept of General Intelligence and Its Measurement; Major Speech Disorders; Minor Speech Disorders; The Left-handed Child; The Mentally Subnormal Child; Special Types of Feeblemindedness; Gifted Children; Special Types of Gifted Children; The Psychoneurotic Child; The Psychopathic Child; The Deaf Child; The Blind Child; The Congenitally Word-blind Child; The Delinquent Child; Other Types of Exceptional Children.* The last chapter includes the epileptic child, the hysterical child, the undernourished child, and the overweight child.

Most of the chapters leave one with the conviction that the writer knows her subject thoroughly. Besides the descriptive material, with its judicious weighing of the various theories that have been advanced concerning the problems under consideration, there are outlines of diagnostic techniques and tests available for diagnostic purposes, and also of remedial methods, especially those that are practical for use in schools. Each chapter is supplied with illustrative cases, followed by questions designed to stimulate the thinking of the student, and a selected bibliography. This supplementary material adds to the usefulness of the book as a classroom text.

The treatment of speech disorders and of left-handedness is especially fine. The author has carefully evaluated the various points

of view with regard to these traits, and her own ideas are based on sound reasoning. The discussion of the effects of change in handedness, which has so frequently been justified or condemned on a wholesale scale, is remarkably sensible. As Dr. Scheidemann points out, changing the child from writing with the left to writing with the right hand may or may not cause the development of speech defects or other difficulties. She emphasizes the fact that the methods used in making the change are more likely to have a traumatic effect than the mere change in handedness itself. She believes, justifiably, that the question of changing a child from the use of the left hand in writing cannot be decided as a general principle, but must be determined in the affirmative or negative for each individual case. Many factors must be considered: the degree of right- or left-handedness, the nervous or emotional condition of the child, the vocational prognosis. Whenever the change of handedness seems to be warranted by the case study, the methods of retraining should also be adapted to individual conditions. Dr. Scheidemann reiterates the necessity of avoiding methods that may create emotional disturbance in the child, such as fear or anxiety, since these emotional states, rather than the change of handedness, are likely to produce unhappy results.

One is loath to offer criticism of a book that is so largely deserving of commendation. But in all fairness, there are some subjects that must be mentioned as lacking the able handling that characterizes the rest of the book. After the author's ample discussion of the problems taken up in the first nine chapters, it is disappointing to come to the short chapter on the psychoneurotic child. While psychoneurotic symptoms are described with a fair degree of clarity, the discussion of etiological factors is not so clear. The suggestions for treatment are limited to indicating the need for special pedagogical methods; there is no reference to individual case study and treatment such as would be characteristic of child-guidance-clinic methods, or to the pioneer work in child analysis that has been initiated by Anna Freud, Melanie Klein, and certain other workers in this field.

In reading the chapter on the psychopathic child, one experiences similar reactions. Here, again, we find a brevity that precludes the presentation of different theories and the clarifying of controversial points that makes most of the chapters noteworthy. For example, to dismiss the topic of sexual inversion with five sentences, one of which is the dogmatic statement that "it is a congenital trait", suggests that the writer is unfamiliar with recent literature on homosexuality. The work of Stekel, Wittels, and others throws much doubt upon the theory that sexual inversion is congenital in nature, as does the clinical study of maladjusted children. Other parts of this chapter might be similarly criticized.

Finally, Chapter XIV also falls far below the general level of the book. Cyril Burt, Arthur Gates, and Leta Hollingworth, to mention a few of the chief investigators of special disabilities, have not accepted the concept of congenital word-blindness. Yet Dr. Scheidemann entitles this chapter *The Congenitally Word-blind Child*, and considers reading disabilities as a mild form of this disorder. Moreover, it seems strange, since she quotes Burt, Gates, and Hollingworth, that she rejects so completely their analysis and criticism of the theory of word-blindness. Again, although Orton's findings with regard to reading disabilities are given in much detail, there is no summary of the findings reported by Gates in his book *The Improvement of Reading*, which is by far the most intensive and extensive study of the problem to date, nor is there any reference to this work in the bibliography at the end of the chapter. A third deficiency in Dr. Scheidemann's discussion of reading disability is the failure to perceive the emotional factors that may have had a place in disturbing the acquisition of the reading process. These have been mentioned by Gates in his book and by the present reviewer (in articles published in MENTAL HYGIENE). Here we have a distinct contrast to the nice appreciation of emotional disturbances in connection with change from left- to right-handedness found in the chapter on that subject.

In concluding, Dr. Scheidemann remarks that remedial teaching methods have not been described in the literature, and that the teacher must devise her own procedure. This, we believe, is an error. Gates gives detailed instructions for remedial teaching in his *Improvement of Reading*, and later published, in collaboration with Huber, a series of readers and work books that may be used in connection with the other special methods he has outlined. A different method has been described by Fernald and Keller. The reviewer has seen the methods both of Fernald and Keller and of Gates used separately or in combination for difficult cases of fourteen-year-old children (of high intelligence) with such pronounced disabilities that they have not progressed beyond second- or third-grade reading skill, and frequently the handicap has been overcome sufficiently to make possible high school or even college work.

To dwell at such length on the deficiencies of this text seems almost unjust, in view of its exceptional merits. But it is just because the book as a whole is so good that these discrepancies are so noticeable. It would be easy to correct them for a revised edition, but even without such changes, the text is one of the most complete and satisfactory in its field.

PHYLLIS BLANCHARD.

Philadelphia Child Guidance Clinic.

NERVOUS INDIGESTION. By Walter C. Alvarez, M.D. New York: Paul B. Hoeber, 1930. 297 p.

Of late there has been apparent a tendency on the part of the internist to see in the patient with nervous indigestion a neurosis explicable in the same terms as are other lesser psychiatric problems. Along with this appreciation there has come a realization that not only is the case of nervous indigestion the result of individual sensitivities coupled with environmental strain, but that even the case of organic gastric disorder, through prolonged irritation or through fear, has a mental component appreciation of which is necessary to coöperative and successful treatment. There is evidence that in some cases psychic problems, with their resultant visceral tensions, may so alter tonus, or perhaps secretion, as to lay the groundwork for or contribute to a real organic disease. Most important in all this has been the tendency to get away from neurological pseudo-explanations, and to accept as legitimate and respectable data for medical evaluation the events of the individual's daily life. Social service can do so much more with these circumstances than the patient or his family that it is coming to be relied on more and more for environmental evaluation and treatment, while psychiatric technique becomes a part of the armamentarium of the gastroenterologist.

In view of this tendency, it is interesting that practically only in the preface of *Nervous Indigestion* does the author refer to the psychiatrist, and then only to revert to the archaic standpoint: "The professor of psychiatry . . . is interested in other things, and besides, most psychopathic persons with indigestion would fear the stigma of having anything to do with a specialist in insanity." While admitting in the preface that he has resorted to the social worker, the author has apparently closed his eyes to the nature of her contributions, for in the pages that follow he gives no serious consideration to manipulation of the situation in which the patient lives or to attempting to analyze the basis for his sensitiveness. Again and again this sensitivity is referred to heredity or to some brain-center or neurological peculiarity. Again and again in his cases, while love or family situations stand out etiologically, they are not dealt with as such or as indications for therapy.

The first chapter brings out some interesting evidences of a relationship between emotions and visceral function, and yet the author seems unable to credit experiential and environmental disorders—things such as conflict, chronic emotional excitation, and life problems—with the value attributable to an organic lesion. There is nothing positive to him in the diagnosis of a psychic problem. Time and again he arrives at such a diagnosis only after the exclusion of organic disease. He pays too scant attention to the fact that both

may be present independently or interdependently, and that the diagnosis of both depends on positive facts. The frustration that must come constantly to one who holds a restricted point of view appears in several places, at times constituting a violent protest against the bafflement presented by the neurotic patient. This protest in some internists is worked out on the patient in terms of scolding or even harsh accusations of malingering and berating. The author himself does not so project responsibility for his frustration. Of lesser degree is the persistent attempt to short-cut the patient's symptoms by such routes as: "If they would only learn not to let other people annoy them, if they would avoid losing their temper . . . if they would control their emotions, they would be well." He might as well add: "If they would heal their ulcers, they would be well." To say, "She must stop talking about it, she must accept the situation as it exists", is helpful only when she is shown how. This includes giving her an appreciation of the basis of anxiety and worry and the obstacles to its elimination.

The author depends greatly on fatigue for etiology and on rest for treatment. He has not adequately analyzed rest in bed so that the rest element is separated from the element of relief from situational problems. The latter element is, of course, merely escaped for the time being, not altered, by rest in bed.

The case-hardening of the physician through restricted attention to miscroscopes, tissue pathology, and the premature translation of data about function into cells and tissues, is the greatest obstacle to progress with the case of nervous indigestion or any other type of mental problem that has discovered a pseudo-organic expression. Perhaps nothing could give the enlightened reader a better appreciation of the era whose concepts this book expresses than to quote a few passages:

"It may be that some of the misery of those nervous persons who are constantly aware of the presence of an irritable colon is due to an oversensitiveness of this and other centers in brain and cord."

"Unfortunately the problem of finding the microscopic lesions that underlie some of the so-called neuroses is complicated by the fact that there are so many places in which the investigator must look. The disease may be outside of the abdomen, in the brain or in the cord, it may be due to smoldering infection in some of the abdominal organs, or it may be caused by sclerotic changes or transient spasms in the blood vessels supplying stomach and bowel."

"The gastroenterologist sees many patients whose primary trouble is a psychopathy. They are worn out and on the verge of a nervous breakdown, not because their work is hard, but because they have

poor nervous heredity, because they spend their mental energies so riotously and so unwisely, and because they adjust themselves so poorly to the demands of the world about them. They fuss and fret openly or silently over little things, and they expend over trifles more thought and energy than a sensible man or woman puts into a week's work."

"She was frantic to win him back, but could not find the strength to mend her ways. Why couldn't she? Because she had an insane sister and this *folie de doute* was her small share of the nervous weakness that has appeared in various forms here and there in her father's relations."

"In all these cases *the physician must focus his attention on the weakness of the patient and on his or her inability to stand up to the strain of life, and not on the aches and pains in the abdomen.*"

"The physician must be on the lookout always for those who are on the border line of insanity or definitely insane because they can make endless trouble for him."

"The only possible way in which to cure them would be to begin all over again with a different set of ancestors."

"Some day I hope that with the new ovarian hormones that are now being isolated and purified we will be able to give these women real help."

"One should ask particularly if the pain wakes the patient at night because any one who is wakened out of a sound sleep and has to get up and walk the floor, go to the kitchen for food, or to the bathroom for a dose of sodium bicarbonate is surely not a neurasthenic."

"It is a sad fact that nowadays many of these patients get from their medical advisers not the rest that they so badly need, but an operation. Instead of being given sedatives and a better diet, they are rushed to the hospital, there to part with an innocent appendix, harmless tonsils, or doubtful teeth. At first sight this may seem inexcusable, but any one who has ever, for an hour or more, struggled ineffectually to get an intelligible and consistent story out of a nervous or psychopathic patient will understand how it is that some physicians and surgeons adopt the, for them, time-saving practice of opening the abdomen and trying to make a diagnosis in the operating room. Sometimes it works, but too often it doesn't."

"The cross-examination of nervous patients requires much time. . . . The busy specialist with expensive offices would lead a far

happier and a much easier life if he could only send many of these persons away the minute he sizes them up. In the time that he must devote to one of them he could easily care for ten patients with peptic ulcer or gallstones."

"Fortunately for the consultant such patients can often be referred back to that long-suffering man, their home physician. Sometimes I have said to them frankly, 'Here, you are wasting your money and I my time, let us part company while we are still friends'."

"All that most of them want to know is that there is nothing seriously wrong."

"If the patient has been overworking and losing a great deal of sleep, I picture to him thousands of delicate brain cells crying out for rest; I suggest that he give heed to their complaint, that he cut down on work, try a simpler diet and better methods of regulating the bowels, and see what happens. If everything clears up, we shall be happy."

"The treatment of the functional disorders of digestion may be discussed under four headings: (1) psychotherapy and instruction in mental and physical hygiene; (2) physiotherapy, exercise, and massage; (3) diet; and (4) drugs."

"When nervous women are told that they need a month in bed, the answer usually is, 'Why I couldn't stay in bed even one day, I'd go crazy'. My answer is that this very statement proves to me how badly they need the rest that I am prescribing. They are living on their nerves."

In the discussion by Dr. Alvarez of his personal relationship with his cases is to be found the chief contribution of this book. Without knowing him, one might safely judge that he himself is a man of good mental health and common sense, qualities that are as much needed as the technical capacity for psychiatric analysis.

GEORGE S. STEVENSON.

The National Committee for Mental Hygiene.

NOTES AND COMMENTS

Legislative Notes

Frederick W. Brown

Director, Department of Information and Statistics, The National Committee for Mental Hygiene

During the current year the legislatures of forty-four states met in regular session and special sessions were held in eleven states. Owing to the large number of bills presented, a final report on some of them is not yet available. The new laws that have been passed and the bills that failed since the July issue of Mental Hygiene are indexed by subject and summarized below. The designations S. and H. refer to bills presented in the upper and lower houses, respectively, of the various legislatures. The chapter number of new laws are given when known. Dates appearing in parentheses following the number of the bill or law refer to the issue of Mental Hygiene in which the bill or law was originally summarized. Laws and bills of purely local or technical interest are not summarized.

New Laws

Index by Subject

Administration and Finance
Georgia, H. 425; Idaho, H. 161; Illinois, H. 927; Iowa, S. 44.

Children: Defective, Delinquent, or Dependent
Alabama, H. 492.

Commitment
California, H. 1423; Georgia, H. 425; Indiana, S. 68.

Guardianship
Georgia, H. 425.

Mental Defectives
North Dakota, S. 40.

Mental Disease
California, H. 1423; Idaho, H. 161.

Mental Examination of Persons Held for Trial
Connecticut, H. 441.

New Institutions, Clinics, etc.
Alabama, H. 492.

Sterilization
Tennessee, H. 1241.

Veterans
Indiana, S. 68.

Alabama

H. 492, Chapter 227 (3/'31). Recreates the State Training School for Girls, making it a correctional and educational institution for delinquent girls.

California

H. 1423, Chapter 636 (3/'31). Amends the law relating to the commitment of persons who appear to be mentally diseased by providing that if the patient is too ill to appear in court, or if such appearance would be detrimental to his mental or physical health, the judge may hold the necessary hearing at the patient's bedside.

Connecticut

H. 441, Substitute Chapter 70. Repeals Section 6431 of the general statutes, relating to insanity pleas in criminal cases, and provides for the mental examination before or during trial of any person committed to a county jail if it appears that such person is suffering from mental disease or is mentally defective. Commitment to a state hospital for mental diseases or to a state school for mental defectives is contingent upon the court's decision as to whether the evidence indicates that the accused is unable, because of mental disease or mental defect, "to understand the proceedings".

Georgia

H. 425, Chapter 185, amends the act of 1918 providing for the commitment of persons with mental diseases, by substituting the name "Milledgeville State Hospital" for the name "Georgia State Sanitarium", and by making provision for the appointment of an attorney by the county attorney to serve in his stead, when necessary, upon the commission appointed to examine a person for whom guardianship or commitment to a mental hospital is sought.

Idaho

H. 161, Chapter 98. Recodifies the law in reference to the state hospitals for mental diseases and changes the names of the "Idaho Insane Asylum" at Blackfoot and the "State Insane Asylum" at Orofino to the "State Hospital South" and the "State Hospital North", respectively.

Illinois

H. 927 (3/'31). Provides for the joint direction and control of all research and educational hospitals by the department of public welfare and the board of trustees of the University of Illinois, the department to have the administration and the university the research, educational, and professional activities. The term "research and educational hospitals" includes, among others, the Institute for Juvenile Research, the Psychiatric Institute, and all similar

institutions to be hereafter agreed upon by the department and the university.

Indiana

S. 68 (2/'31). Provides for the commitment of veterans to government owned hospitals.

Iowa

S. 44. Amends Chapter 197 of the code, 1927, by integrating the State Psychopathic Hospital with the College of Medicine and the Hospital of the State University of Iowa.

North Dakota

S. 40. Defines a "feebleminded person" as "any person, minor or adult, other than an insane person who is so mentally defective as to be incapable of managing himself and his affairs, and to require supervision, control, and care for his own or the public's welfare", and provides for the removal of non-resident feebleminded persons from the state.

Tennessee

H. 1241. Provides for the sterilization of inmates in state hospitals for mental diseases and the state home for mental defectives.

BILLS THAT FAILED

Index by Subject

Administration and Finance
California, H. 1146, 1147; Illinois, S. 231; Kansas, H. 113, H. 220; Michigan, H. 431; Missouri, H. 589, S. 378; New York, H. 442; Pennsylvania, S. 53.

Children: Defective, Delinquent, or Dependent
Connecticut, H. 463; Kansas, H. 36.

Criminal Insane
California, H. 897.

Defective Delinquents
Connecticut, H. 591.

Discharge
Pennsylvania, H. 360.

Epileptics
Michigan, H. 472.

Marriage and Divorce
Illinois, S. 389; Michigan, H. 533; Pennsylvania, H. 1511, S. 551; South Carolina, H. 117.

Mental Defectives
Connecticut, H. 591; Kansas, H. 113; Pennsylvania, H. 1753.

Mental Diseases
Connecticut, S. 295; Illinois, S. 389; Kansas, H. 113; Rhode Island, H. 744; Washington, H. 169.

Mental Examinations of Persons Held for Trial
Nebraska, H. 209; New Hampshire, S. 10; New York, H. 441; Pennsylvania, H. 1144, H. 1783, S. 815; Washington, H. 169.

New Institutions, Clinics, etc.
Arizona, H. 92; Michigan, H. 447; Missouri, H. 617; New York, H. 575; Texas, H. 400; United States, S. 5093, S. 5113.

Prisoners
Pennsylvania, H. 1753.

Sterilization
California, H. 918; Georgia, H. 69; Indiana, H. 304; Iowa, H. 578; Michigan, H. 472; Missouri, H. 594; Ohio, S. 20; Pennsylvania, H. 1209.

Arizona

H. 92 (2/'31). Would have provided a rest home for mothers suffering from temporary mental disturbance.

California

H. 897 (3/'31). Would have amended the Penal Code by reducing from one year to six months the period that must elapse before the granting of a hearing to determine whether sanity has been restored in the case of the criminally insane.

H. 918 (2/'31). Would have provided for the voluntary sterilization of persons not in institutions.

H. 1146 (3/'31). Would have created a bureau of psychiatry in the state department of institutions.

H. 1147 (3/'31). Would have provided for state rehabilitation of narcotic addicts.

Connecticut

H. 463 (3/'31). Would have prohibited the keeping of children between four and eighteen years of age in almshouses and have repealed the existing law relating to the inspection of homes where minors are boarded.

H. 591 (2/'31). Would have provided for the care and segregation of defective delinquents and vicious mental defectives.

S. 295 (3/'31). Would have provided for the extradition of persons of unsound mind.

Georgia

H. 69 (3/'31). Would have created a state board of eugenics and have provided for the sterilization of the mentally diseased and defective.

Illinois

S. 231 (3/'31). Would have provided new regulations governing the licensing and supervision of child-welfare agencies.

S. 389. (2/'31). Would have made incurable mental disease of five years' duration cause for divorce.

Indiana

H. 304 (2/'31). Would have permitted the sterilization of criminals on order of court or jury.

Iowa

H. 578. Would have provided for the sterilization of mental defectives in state correctional institutions.

Kansas

H. 36 (2/'31). Would have provided for the care of delinquent children and juvenile criminals and for the appointment of a commission to investigate such children.

H. 113 (3/'31). Would have provided that the families of inmates of state mental hospitals and state schools for mental defectives and epileptics be *not* liable for their maintenance unless they receive money or property from said inmates.

H. 220 (2/'31). Would have created a child-welfare board and have transfered the supervision of correction and charitable institutions to it from the state board of administration.

Michigan

H. 431 (3/'31). Would have established a public institutions improvement board and visiting committee.

H. 447 (2/'31). Would have authorized the establishment of a psychiatric clinic at Jackson State Prison.

H. 472 (3/'31). Would have exempted from sterilization persons afflicted with traumatic epilepsy.

H. 533 (3/'31). Would have authorized the circuit courts to require persons in divorce cases to submit to physical and mental examinations if deemed advisable.

Missouri

H. 589 (3/'31). Would have placed all hospitals and institutions treating nervous and mental patients, except state institutions, under the state board of health.

H. 594 (3/'31). Would have created a state eugenic board and have provided for the sterilization of inmates of state mental hospitals and the state school for mental defectives and epileptics and of certain prisoners.

H. 617 (3/'31). Would have provided appropriations for extensive improvements of state institutions and the establishment of new institutions from 1931 to 1944.

S. 378 (2/'31). Would have created the division of mental diseases in the state board of health.

Nebraska

H. 209 (2/'31). Would have provided the procedure for determining the mental capacity of defendants in criminal prosecutions.

New Hampshire

S. 10. Would have provided for the mental examination of persons accused of crime.

New York

H. 441 (2/'31). Would have authorized the court to appoint psychiatrists to examine the defendant when a defense of mental disease or mental defect at the time of commitment of a crime is offered.

H. 442. Would have created in the department of mental hygiene a board to determine and certify qualified psychiatrists.

H. 575. Would have created a psychiatric clinic in connection with the probation department of the court of general sessions in New York City.

Ohio

S. 20. Would have provided for the sterilization of certain mentally defective and epileptic persons.

Pennsylvania

H. 360. Would have permitted the court to admit in evidence the sworn statement of the hospital physician as to the condition of a patient seeking from the court discharge from a mental hospital.

H. 1144. Would have provided for the mental and physical examination prior to sentencing of all persons who plead guilty or who are convicted of crime.

H. 1209 (3/'31). Would have authorized sterilization of mental defectives.

H. 1511 (3/'31). Would have made hopeless mental disease for a period of ten years grounds for divorce.

H. 1753 (3/'31). Would have prohibited the placing of mentally defective prisoners in underground cells or rooms and have provided for their treatment.

H. 1783 (3/'31). Would have authorized the appointment by various courts of psychiatrists or alienists to make mental and physical examinations of all persons who plead guilty to or are convicted of crime, such examination to be made prior to sentencing.

S. 53 (2/'31). Would have imposed upon the state the entire cost of care, maintenance, and discharge of mental patients.

S. 551 (3/'31). Would have made mental disease cause for divorce.

S. 815 (3/'31). Would have provided for the mental examination by two psychiatrists, appointed by the trial court, of any person held for trial by any court of oyer and terminer on a charge of murder.

Rhode Island

H. 744. Would have provided for the temporary care of mentally diseased persons.

South Carolina

H. 117 (3/'31). Would have required medical certificates indicating freedom from venereal disease of males before issuing of marriage licenses.

Texas

H. 400 (3/'31). Would have established a state prison psychopathic hospital.

United States Congress

S. 5093 (2/'31). Would have authorized the erection of a Veterans' Bureau hospital in the southern part of California.

S. 5113 (2/'31). Would have authorized the erection of an addition to the Veterans' Bureau hospital plant No. 100 at Camp Custer, Michigan.

Washington

H. 169 (3/'31). Would have changed the procedure governing the determination of the sanity of persons accused of a capital offense.

Report of the Subcommittee on College Mental Hygiene

The Subcommittee on College Mental Hygiene which was appointed at the National Conference on College Hygiene in Syracuse, New York last May, to formulate desirable minimum standards for college mental-hygiene service, has completed its work and presents its conclusions in the following report.

Although mental hygiene has been appreciated as a need in colleges and universities for fifteen or more years, it is only within the last six years that there have been active developments in this direction. The inclusion of this new element into the activities of colleges should be an evolutionary process since it must relate itself to the age-old traditions of academic life. As each educational institution has its own individual characteristics, no two can be approached in the same way. Therefore, any too rigidly formulated standards might tend to hamper normal growth and interfere with the necessary experimental period.

Mental-hygiene activities in colleges manifest themselves in two ways:

1. As didactic lecture courses which aim to provide the student body with mental-hygiene information.
2. As mental-hygiene service for the assistance of individual students.

LECTURE COURSES ON MENTAL HYGIENE

Your committee recommends that courses on mental hygiene should be a part of the curriculum in all colleges and universities. Such courses should arise out of the individual needs of the individual college or university. Such courses will tend to take one of the following forms:

(a) Orientation courses for freshman as a part of a general individual help and orientation program.
(b) Elective courses on mental hygiene for undergraduates.
(c) Elective technical courses for graduate students in which mental hygiene is related to their particular professional needs.

It is the opinion of your committee that no course in mental hygiene should be compulsory. The committee also wishes to draw special attention to the aims and content of courses and the relationship between these and the background and training of the lecturer. The material usually presented in lecture courses or seminars on mental hygiene tends to fall into one of two types:

(a) Content that deals with the social problems that arise on the basis of mental maladjustments, and the social resources which the community has developed for meeting them.
(b) Courses that aim to provide the student with informational content that may help him to solve his own personal problems.

Although it is recognized that it may not always be possible or desirable rigidly to separate these two types of content, the committee believes that it is essential to recognize the therapeutic nature of the (b) type of content and strongly urges that lecture courses or seminars of the (b) type be conducted only by those who have had a broad clinical experience with mental problems, and who are cognizant of the dangers and advantages of using the didactic method as a therapeutic instrument. The qualifications for such a person are outlined under the caption *Desirable Training of the Psychiatrist.* Courses of the (b) type would best be considered as a part of the mental-hygiene service for individual students and should probably not be given unless such service is readily available to students who may need it.

MENTAL-HYGIENE SERVICE FOR INDIVIDUAL STUDENTS

Mental-hygiene service with students should be clearly distinguished from college administrative and disciplinary procedures, scholastic planning and counseling service, and from services which aim primarily at vocational guidance and placement. Although a mental-hygiene service will frequently function in the closest coöperation with these services, it will, as a rule, be mostly concerned with the difficulties which arise out of the student's social and emotional life, as he attempts to adjust himself to the college situation and the life problems which confront him at this stage of his development. Each type of service will of necessity develop its own techniques and philosophies. If the best interests of the student are to be served, their approach to the student and their points of view must be different. It is essential that they be coöperatively related to each other, but neither type of service can nor should usurp the function of the other—for instance, a college mental-hygiene service should not be used as a disciplinary agent. Discipline

and therapy are at many points mutually contradictory. The function of therapy is to assist the student to make an optimum adjustment to the facts of the situations which surround him rather than to impose penalties or to participate in the carrying through of administratively determined consequences.

In every university there are individual deans, counselors, and other faculty members, including sociologists, psychologists, and physicians, who because of their interest in the individual student, or because of their knowledge of human behavior and social situations, are able to assist students in the solution of their personal problems. Such problems may be administrative, scholastic, social, or emotional. The assistants given is in many cases priceless, but it is impossible to meet the total mental-hygiene problem of the student body in this way. There is a vast difference between a well-organized mental-hygiene service and the valuable assistance which a member of a university faculty may be able to render an occasional student. A specially trained and organized staff are needed before a professional mental-hygiene service for students can be said to exist.

A MEDICAL FUNCTION

Mental-hygiene service for individual students is a therapeutic service which should be conducted under the directorship of a psychiatrist, and should be functionally attached to the department having responsibility for the health of the student body.

DESIRABLE MINIMUM STAFF

Your committee recommends:

1. A full-time psychiatrist. (Small colleges may find it necessary to organize this work on a part-time basis, even though this has manifest disadvantages.)
2. Availability of an organized general medical service.
3. Availability of psychological service.
4. Availability of social service.

DESIRABLE TRAINING OF THE PSYCHIATRIST

The psychiatrist should

(a) Be a person who on the basis of his personality is able to gain and hold the respect of the members of the student body and the college faculty.

(b) Have had a thorough background of theoretical training and a broad experience in the field of clinical psychiatry in order that he may be competent in the diagnosis and treatment of the more serious mental disorders.

(c) In order that he be capable of handling the vast majority of student problems which are minor social and emotional maladjustments rather than serious mental disorders, the psychiatrist should have had adequate training in the modern dynamic principles of psychiatry which are gained by:

1. Experience in the management of behavior problems in children acquired through working as an integral part of a well-organized child-guidance unit or something similar.

2. Experience in the management of problems arising out of family situations, and thorough familiarity with the contribution to psychiatry of the trained social case-worker.
3. Experience in modern dynamic psychotherapeutic techniques.

Your committee recommends that colleges and universities which are interested in the development of a college mental-hygiene service for students avail themselves of the accumulated knowledge with respect to this type of service by consulting experts in this field. The National Committee for Mental Hygiene, 450 Seventh Avenue, New York City, is in the best position to advise in the selection of experts. Experience in this and related fields indicates that mental-hygiene service can be intelligently planned only if the special conditions in each college are recognized and met. Your committee realizes that the problems confronting the smaller and larger colleges, the state universities, and the privately endowed colleges, the men's, women's, and coeducational institutions, all require special and individual consideration. Therefore, in submitting these recommendations, your committee realizes that the desirable minimums set forth can be only tentative.

An Educational Tragi-Comedy

By W. B. Curry

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The reflections embodied in the present essay arise from the fact that the writer, as one actively engaged in education, has been impressed by the irrelevance to his own chief perplexities of much of the educational research which is going on in the colleges. A great part of what is called research must, of course, be dismissed at once as mere stupidity.

From time to time I receive questionnaires from aspirants for Ph.D. degrees engaged in the writing of a thesis. Not long ago, I received a perfect specimen in which I was asked to state the time devoted in my school to each of a variety of "objectives". Among other things I was solemnly asked to state the amount of time spent daily in teaching "emotional control". This questionnaire emanated from the educational department of a well-known university and, presumably, it was sent out with the consent of the head of the department. Perhaps it was supposed that in, say, the nursery school we spend from 9:30 to 9:50 each morning in teaching emotional control.

At all events, this particular piece of imbecility was by no means an extreme example of its kind, and I have received a great many such questionnaires, the answers to which, when collected and treated with the right statistical alchemy, could serve no conceivable purpose except that of earning the collector the coveted Ph.D. But even

turning to the work done by more serious students, I cannot feel that what is being achieved has any importance compared with that of the major unsolved problems in education.

Immense time and trouble are devoted to various methods of improving the technique of teaching. This work is useful and, if a given piece of arithmetic can be taught in three days instead of in four, so much the better, but it can hardly be claimed that advance along this line is likely greatly to enhance the quality of our civilization. But also, a great deal of what is called research seems to me either positively useless or pernicious. For example, researches in the curriculum are being carried on which claim to be scientific, but which are yet based, unconsciously perhaps, upon a philosophy which ought to be opposed by all who care for civilization. There are workers in the universities who solemnly ask a collection of business men what facts they have found it most useful to know, and then suggest that these facts ought to form the basis of a new curriculum. Or, again, a group of workers at Teachers College have, with incredible industry, arranged some thousands of words in the order of the frequency of their occurrence. It is thus possible for a teacher to know which hundred words are most used in the English language. What he is to do with the knowledge, I am not quite sure. I can hardly suppose that he is to ask his children to learn these words as mere words, nor can I suppose that people are to be employed to write stories using only these words, though this, no doubt, would be a useful piece of "creative research" for some one.

What most of these workers seem to forget is that education, at bottom, is not a science at all. Any education will have, or ought to have, as part of its object the creation of civilized communities of adults. What a civilized community is remains, of course, a matter of dispute. What we feel to be its attributes will depend in each one of us upon our general attitude toward life and the sense of values we have developed, but it is just for this reason that any one who values the idea of a liberal education will feel horror at the suggestion that facts which business men have found it useful to know should be a basis for a curriculum.

This is not an imaginary danger. Recently a certain music school which provides instruction at low rates for children of the poor was appealing for funds. It circulated leaflets describing the value of music and it was astonishing to note how grossly utilitarian many of these were. For example, one leaflet was entirely concerned with the fact that, in certain factories, music played during the work increases output. Surely there has never been a time before in the history of the world when it was necessary to defend music by advocating it as a means of diluting the noise of a factory! Presumably

it was thought that this appeal would be effective or it would not have been made, but that it should have been made is a grave reflection on our prevailing notions of value.

With this idea in mind, that education has to do with the production of civilized communities, let us turn now to some problems on which real leadership is required. I have in mind particularly three problems of which most teachers are not fully aware, and on which few have developed any clear ideas. Take, for example, the question of peace and war. There is a wide consensus of opinion that the next major conflict may destroy our civilization, and yet the possibility of another first-class war seems far from remote. Nevertheless, the average human being is not merely indifferent to this problem, but is equipped with a set of habitual attitudes which means that, with very little trouble indeed, he can be aroused to any extremity of patriotic bellicosity.

We are aware that the problem has to do partly with the manner in which history is taught in the various countries, but it is clear that the matter goes much deeper than this and that fundamental attitudes are involved. If adults are to be changed in this respect, the problem is one for education to solve. It is my own personal belief that the average school inculcates in its pupils patterns of group behavior which lead inevitably, in adult life, to the most virulent forms of patriotism. Furthermore, patriotism seems to be, not an instinct, but a sentiment, and, as such, capable of profound modification by means of education. This, however, is an opinion and the opinion of one who is not an expert in psychology. Surely, as a problem which deeply concerns the whole future of our civilization, it is well worth the serious and detailed attention of experts. It would be infinitely more valuable to know how to bring up a generation of children who would know how to live together peaceably than to know how to save 10 per cent of the time now spent in the teaching of the multiplication table. Yet I know of hardly any serious work being done on this subject except by amateurs.

"Adjustment" is one of the most commonly used words in modern education and has, indeed, attained the status of a new "objective". It is, however, clear enough that we are all very badly adjusted to life, as it is going to be lived, if we are at any moment liable to attacks of mass insanity leading to large-scale war. Nevertheless, every one knows that in nine schools out of ten, all the practices which were in vogue before the last war for the promotion of "right thinking" on international matters are still in vogue. If the generation which is growing up is being trained in much the same way as the generation which plunged into the late War, then, presumably, it will plunge into its own war in due course. The present activity

of pacifist leagues in this matter seems to me almost childishly irrelevant. I should like myself to see a serious psychological study of the whole background of emotional conditioning in childhood which is productive of the present attitudes of adults toward international affairs. This would be a big and difficult task, but it would require no more effort than is now being spent on subjects which are incomparably less important.

This leads to the cognate and, perhaps, identical problem of partisanship in general. Our civilization demands increasingly the ability to coöperate with others and the ability to imagine the needs and desires of those outside of one's immediate, instinctive circle. To my mind, though this is again the opinion of an amateur, a great deal of partisanship which most people regard as virtue and dignify by the name of loyalty has become in many spheres a major obstacle to progress. For example, if in the British coal industry the coal miners were less loyal to coal miners and the coal owners to coal owners, it is probable that a solution of the difficult problems facing it might have been arrived at and put into practice before the problem had become as acute as it now is. It never occurs to the average human being that loyalty can ever be a vice. I take it that this is partly the result of instinct and partly the result of the conditioning which instinct has received in school and in the home. At all events, here again is a problem of immense importance which schools are doing nothing whatever to solve and in which the teachers' colleges in particular seem to give no leadership.

A third problem worth considering is that concerned with individuality. In old-fashioned schools the sense of the value of the community is developed by what might be called militaristic methods. In modern schools there is a reaction from this and the individual is considered all-important. There is, therefore, wide criticism of children brought up by modern methods as being inconsiderate and without any proper feeling for the rights of others. There is here a really difficult, psychological problem. In the English public schools and in many American adult communities, the sense of the community means, among other things, the destruction of individual eccentricity and a belief that everybody should be like everybody else.

Most liberals deplore this attitude and bring up their children without respect for conformity. But anarchism, like patriotism, is not enough. It is quite clear that in any society whatever, there must be some sense of responsibility for the genuine, common interests of the community. There should be not only respect for the rights of the individual on the part of the chief organs of community opinion, but also a respect by each individual for the indubitable rights of others. How is it possible to achieve this without resorting to the

old-fashioned methods which produce, at the same time, undesirable forms of herd instinct? How, in other words, are we to produce in our schools free, creative individuals jealous of the rights of individuality, and, at the same time, citizens capable of coöperation and filled with an adequate sense of responsibility?

Most existing schools and most teachers are aware of only one side of this problem. I do not believe that it has been adequately considered by experts or that data exist for a complete solution. It might be suggested in reply that this is one of those questions which will be solved only by a genius, and that the personality of the genius will be the determining factor. But if only a genius at the head of each school can preserve the necessary balance, then the future will be dark indeed. But probably this is not the case: for example, the modern English public-school system was, no doubt, largely due to the genius (if we wish to call it such) of Dr. Arnold of Rugby. Nevertheless, when once a technique had been developed, others were able to perpetuate his ideas without needing his original inspirations. I am not an admirer of these schools and I quote them simply as affording evidence of the way in which a technique for producing certain attitudes may perpetuate itself successfully for several generations. In these days, however, there is such a parade of the new science of education that one would expect its practitioners to be attempting, by their own methods, the solution of these important problems instead of waiting for the inspiration of the mere artist in education.

My contention, then, is that, on the one hand, an immense amount of time and thought and money are being spent on researches which, however useful in their way, are of minor importance if we think of education as being chiefly the torch-bearer of civilization, while, on the other hand, little direction is being given from the acknowledged leaders of educational theory and practice in the methods by which the teachers in the schools may help to train a generation that is likely to grapple more successfully than ours has done with the main problems which threaten the security of civilization.

The Spirit of Science *

In the following paragraphs, David Dietz in *The Story of Science* has made as fine a summary statement as we know:

> Science has proved a powerful tool in the hands of modern man. It has given him the steamship and the railroad, the telegraph and the tele-

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phone, the electric light and all sorts of electrical machinery. He goes under the sea in the submarine. He speeds through the air, across the Atlantic, or over the poles of the earth, in an airplane. He circumnavigates the globe in a Zeppelin. The radio carries his voice across continents and oceans with the speed of light. These are the practical applications of scientific knowledge. But they hold danger for mankind as well as help. The chemical plant which manufactures perfumes and dyestuffs can be converted overnight into a poison-gas factory. The airplane and the submarine can be used for havoc and destruction. If science brought only its practical applications, it might prove the eventual undoing of mankind.

But science brings also a spirit, its own guiding spirit, and in this there is hope for mankind. To the scientist, the practical applications have always been secondary. He has sought primarily to understand nature and the universe. Galileo, meditating upon the laws of motion, was trying to understand the workings of nature. He was not thinking of engines and machines. Maxwell, seeking to explain the nature of light, had no thought of the radio. This does not mean that science is contemptuous of its practical uses. The opposite is true. But it does mean that the true scientist is motivated by a higher aim than that of making life easier. He wishes also to ennoble and enrich life. The spirit of science, then, is, first of all, the wish to know, the urge to seek, the desire to comprehend the universe.

Secondly, the spirit of science is the spirit of courage. The scientist is not bound by ancient tradition. Copernicus dared to cast aside the Ptolemaic theory though it had dominated man's thought for centuries. Vesalius challenged the authority of Galen's anatomy even though it had ruled since the time of the Romans. Scientists did not fear Newton's *Principia* because it was new. They did not flee from Maxwell's electromagnetic theory of light because it was revolutionary. Twentieth-century scientists have not rejected Planck and Rutherford and Schrodinger and Einstein because their ideas were new. On the contrary, they rejoiced in each new discovery.

Third, science is the spirit of tolerance. The scientist knows there is no monopoly upon truth. He sees the advance of science as a great co-operative venture of all nations and peoples down through the years. The roll of every science is an international one. Copernicus was a Pole; Tycho, a Dane; Kepler, a German; Galileo, an Italian; Newton, an Englishman. The story is the same to-day. The theory of Einstein of Germany receives its chief verification at the hands of English and American scientists.

The scientist is tolerant of other men's points of view. Realizing how frequently he must change his own views in the face of new evidence, he is never scornful of the other man's point of view. He realizes how little mankind knows and how much is yet to be learned and the realization makes him tolerant.

And, finally, the scientist is humane. He is concerned for the future of mankind. The picture of the scientist as a man who shuts himself away in his laboratory like a hermit in a cave is an unfair picture. There are, of course, such individuals, but they are not representative of science.

Let Einstein, whose theories represent man's greatest flight to-day into the world of the abstract, speak for the scientist's interest in the

concrete facts of life. In February, 1931, while visiting in Pasadena, he addressed the students of the California Institute of Technology.

"Why does this magnificent applied science which saves work, and makes life easier, bring us so little happiness?" he said. "The simple answer is: Because we have not yet learned to make sensible use of it."

"It is not enough that you should understand about applied science in order that your work may increase man's blessings," Einstein told the students. "Concern for the man himself and his fate must always form the chief interest of all technical endeavors. Never forget this in the midst of your diagrams and equations."

The scientist looks back over a universe ten trillion years old. He sees the earth emerge two billion years ago in a great cataclysm to the sun. He sees life begin a billion years ago as tiny microscopic cells. He watches the slow evolution of life through the ages, the sponges, the creeping things of the ocean, the fish, the amphibian, the reptile, and the mammal. He sees man emerging a brief twenty-five thousand years ago as the dominant creature on the earth. He follows man's career and sees man rising slowly upon the wings of knowledge. Progress is slow. Man is retarded by fears and superstitions, by selfishness and greed. At times progress seems to stop as men make war and rob and kill each other. But wars end and progress is again resumed.

The scientist realizes how very young scientific knowledge is. Less than 500 years have elapsed since the days of Copernicus and Vesalius. It is less than 400 years since Galileo first turned his little telescope upon the heavens. The modern atomic theory is less than 150 years old. It is less than 50 years since man learned of the X-rays, of radium and the electron. As Bertrand Russell has said, "We know very little, and yet it is astonishing that we know so much, and still more astonishing that so little knowledge can give us so much power."

And so the scientist, conscious of the smallness of his knowledge, and also conscious of the greatness of the power which so little knowledge has given him, faces the future with courage. He sees indications in the stars of a probable life of ten trillion years for the earth and he visions mankind marching down the ages, his comprehension of the universe growing greater and greater, his mastery of nature and of himself ever increasing. The ancient Psalmist, standing beneath the stars, exclaimed:

> "When I consider Thy heavens, the work of Thy fingers, the moon and the stars, which Thou hast ordained; What is man, that Thou art mindful of him? And the son of man, that Thou visitest him?"

But the ancient Psalmist understood the greatness of man as well as the greatness of the universe, for he added:

> "Yet Thou hast made him little lower than the angels, and hast crowned him with glory and honor. Thou hast made him to have dominion over the works of Thy hands; Thou hast put all things under his feet."

Science looks forward with confidence and courage to the day when man shall realize the best that is in him.

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INDEX TO AUTHOR, TITLE, AND SUBJECT

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[illegible]

[illegible] PURPOSES

The National Com[illegible] Menta[illegible] through its affiliated state societies and [illegible] of mental health, the reduction and pre[illegible] and delesion the improved care and treatment of [illegible]; the [illegible] training and su[illegible] the [illegible] and dissemination of reliable [illegible] factors [illegible] in the problems of [illegible], [illegible], and other related to the br[illegible] to accomplish its purposes by [illegible] research [illegible] causes of nervous and mental diseases and [illegible] studies of mental-hygiene problems; app[illegible] through schools and the promotion [illegible] psychiatric social work; establishing child [illegible] developing trained personnel; and [illegible] agencies whose work touches [illegible]

When one [illegible] be benefited by organized work in [illegible] at once become apparent. [illegible] only [illegible] and those suffering from mental [illegible] causes, are unable so to adjust themselves [illegible] and efficient lives.